The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

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ABSTRACT

In recent times the status and reach of nursing has dramatically improved to levels where nurses can now be seen as authentic and legitimate producers of globally relevant healthcare knowledge in various areas of speciality including tissue viability. Yet there are still notable gaps in the status and professional credibility of nurses and the perceived value of their knowledge in different geographical locations. This thesis consequently sets to explore the professional status of nurses in four Middle Eastern countries (Kuwait, Qatar, Jordan, and Egypt) relating to wound management and skin integrity. It aims to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity through the concept of professionalisation. This research uses an exploratory qualitative approach to serve its aims and provide an in-depth understanding related to the absence of nursing specialisation in tissue viability in Kuwait, Qatar, Jordan, and Egypt. A purposive and snowball sampling identified the relevant key decision makers and gatekeepers in the chosen countries hospital directors, nurses in clinical and administration positions, doctors, and policymakers. Primary data was collected using semi-structured in-depth interviews between November 2021 to November 2022. A total of 32 interviews were conducted exploring the current and actual practices related to wound management and skin integrity in Kuwait, Qatar, Jordan, and Egypt. Thematic analysis was used for data analysis. A number of critical issues related to conducting research during the time of the pandemic and the impact of power on operations and organisational structure in the research are reflected. The research findings contribute to understanding the wider structural, cultural, and social forces that influence on the development of nursing professionalisation, in Kuwait, Qatar, Jordan, and Egypt, and specifically to developing specialist tissue viability nurses. The findings from this research can be used as a reference for future research in healthcare from those countries reflected upon or the themes can be expanded to research other geographical locations and socio-political spaces.

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LIST OF ABBREVIATIONS AND ACRONYMS

TVN:	Tissue Viability Nurses
WHO:	World Health Organisation
UK:	United Kingdom
NUH:	Nottingham University Hospital
SAUC:	Sabah AlAhmed Urology Centre
MOH:	Ministry of Health
OPD:	Out-Patients Department
GCC:	Gulf Cooperation Council
JCI:	Joint Commission International
QCHP:	Qatar Council for Healthcare Practitioners
HMC:	Hamad Medical Corporation
ENS:	Egyptian Nursing Syndicate
COVID:	Corona Virus Disease
DM:	Diabetes Mellitus
DMP:	Data Management Plan
NMC:	Nursing and Midwifery Council

CHAPTER ONE
INTRODUCTION

1.0. My Journey to this PhD

Problems related to skin integrity are considered as a significant issue globally, several research have discussed the issues of skin integrity and wound management. However, this research is considering the absence of specialised tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt. The journey toward this PhD started from my background as a nurse, where I have seen many patients with complicated wounds and as a nurse, I was not able to do anything for them. At a personal level, my father and grandmother suffered from severe wounds and skin issues but as a nurse, I could not deal with their wounds. I was just relying on doctors' opinions, which sometimes did not satisfy me. I was not able to make any decision, which might be because of my lack of knowledge in this area, or due to fear of stepping out of the system, whereas any decision could put me in trouble.

In 2015, I was a part of the safety team and quality coordinator in my organisation in Kuwait (Sabah AlAhmed Urology Centre). This team was responsible for checking and measuring safety indicators in the hospital and critically analysing the issue to avoid harm. Considering my background as a general nurse who worked in the surgical ward and then in the Out-Patients Department (OPD) I have seen several patients coming to OPD with wound infections. Some of the patients apply different things such as herbs, to the wound which makes the wound deteriorate. On the other hand, as a nurse, I could not do anything except follow doctors' instructions to clean wounds and apply dressing. In 2017/2018, I pursued my Masters's degree in the UK, during this period of over one year, I visited the hospital for few times, where I observed that a nurse's role is way more than following doctors' instructions or doing basic care like monitoring vital signs or giving medications. I wonder why in the United Kingdom (UK), nurses are different and why they have different nursing specialities while in Kuwait they do not exist. Following that in 2019, I started my journey toward a PhD by contacting a professional related to skin integrity (Professor Christine Moffatt). The journey during PhD is shown in Figure 1.1.

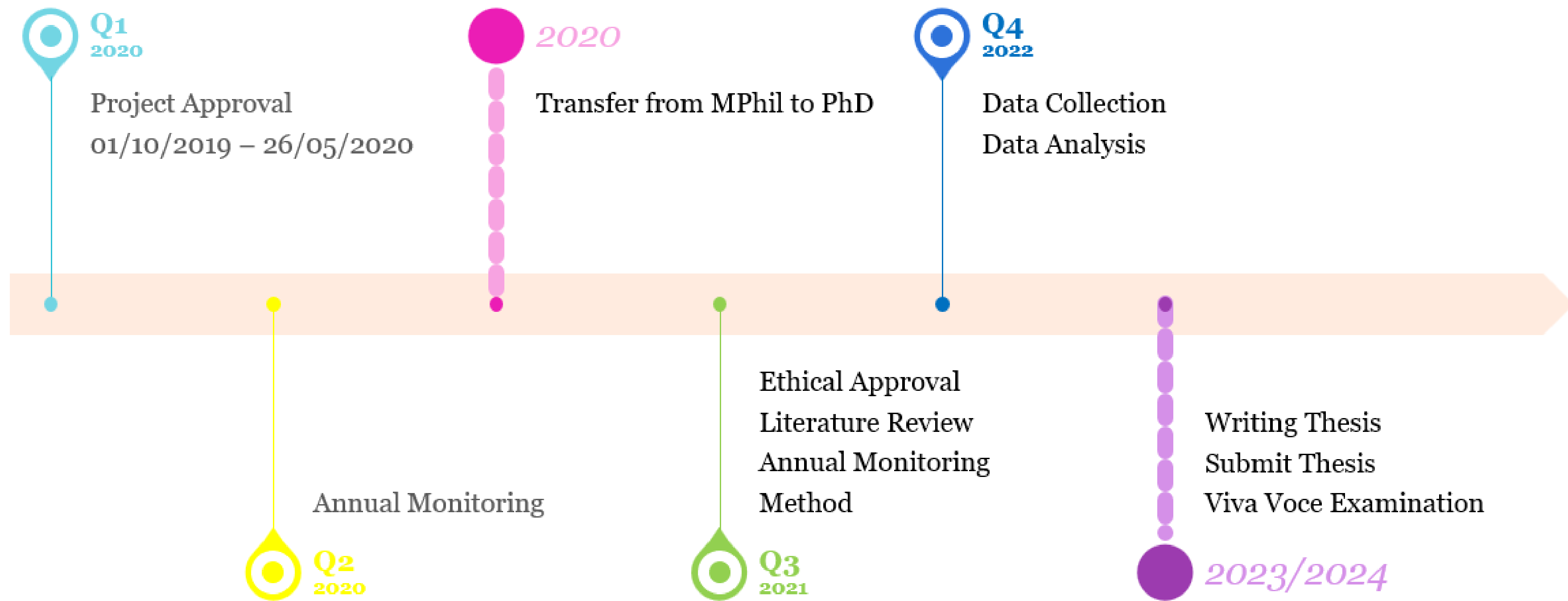


Figure 1.1: Key Milestones During PhD

During my visits to hospitals in the UK, I came to know about Tissue Viability Nurses (TVNs) for the first time. I heard about this speciality, and this made me enthusiastic to explore more about this speciality and nursing role in managing chronic wounds and improving skin integrity. I need to understand the TVNs role, considering my background in the surgical department and further my role as a nursing in-charge and quality coordinator and in-charge. Moreover, in 2021, my mother got a foot ulcer and there are no specialist nurses from whom I can seek their opinion. This gives me more dedication and motive to understand the absence of TVNs in Kuwait. I believe if there are specialised nurses in wounds in Kuwait, then wound-related issues could be managed without waiting for doctors who are usually busy, and it is difficult to approach them or get an appointment with them. This delay made my mother suffer and her condition got worse. My interaction with my mother gave me more dedication to this research, to understand the lack of this speciality and how this affects several people in my country apart from my mother.

1.1. Changes in the Research Scope and Design

The original research scope is based in the UK and Kuwait; to explore TVNs and wound management in the UK and Kuwait. However, the revised research scope has changed in terms of research focus (diverting, from the UK to Kuwait). This research went through two major changes in the design. First due to COVID-19 and then due to a lack of participants from Kuwait. Figure 1.2 shows the two major changes in the research scope. Initially, Nottingham University Hospital was planning to introduce a strategy for improving skin integrity through a partnership with Professor Christine Moffatt and Professor Linda Gibson at Nottingham Trent University. The aim was to address the nurse's role in wound management at Nottingham University Hospital (NUH) and Kuwait, Sabah AlAhmed Urology Centre (SAUC) and further identify the enablers and barriers to implementing a strategy related to wounds and skin integrity in Kuwait. For that, the methods proposed to be used were in-depth interviews, interview schedules, clinical vignette documentary reviews and analysis, baseline surveys and observations of the clinical practice. However, due to the pandemic of COVID-19 and due to the health restrictions in the UK and difficulties in accessing respondents from (NUH) it was convenient to focus on Kuwait only. Therefore, the methods changed as shown in Figure 1.3.

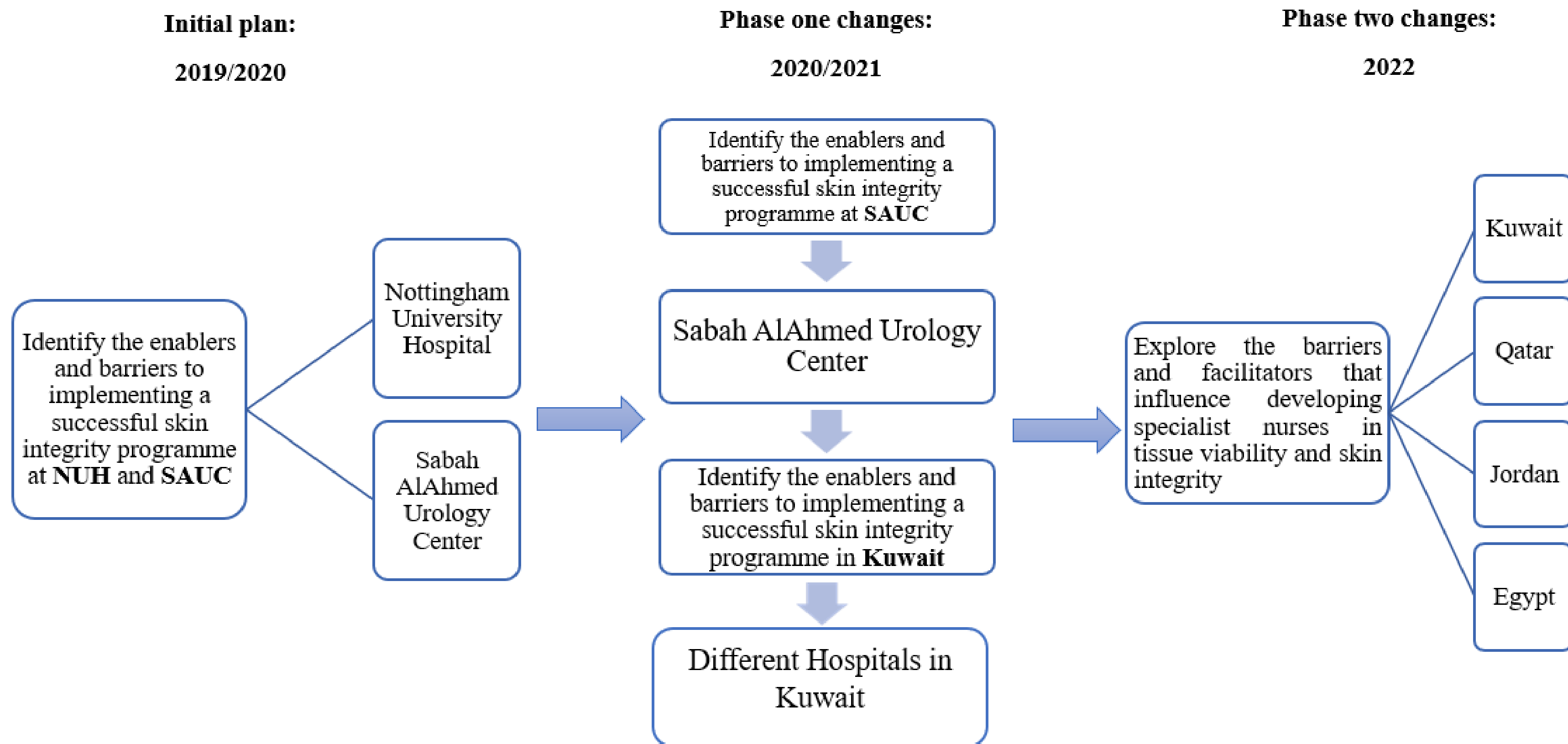


Figure 1.2: Research Scope Changes

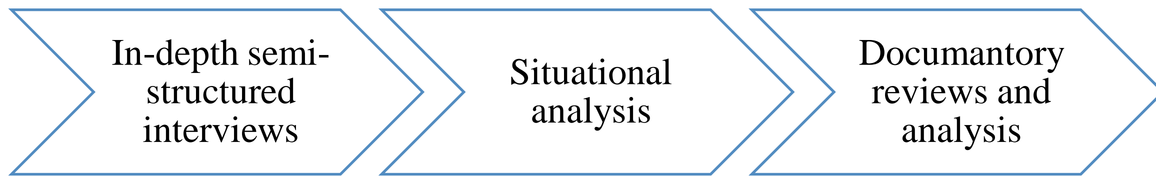


Figure 1.3: Research Method Changes

The change in the research methods and shifting the research focus from the UK to Kuwait only, particularly (SAUC), helped to focus more on Kuwait, which required searching in-depth for literature about Kuwait in Arabic and English. Despite that, there is a lack of research related to the nursing profession, wound management, and skin integrity in Kuwait. Further, developing the research methods and interview questions in Arabic as well as English is a requirement from the Ministry of Health (M.O.H.). As a researcher, I need to be flexible to adapt to the rules and guidelines of the country. However, SAUC has been transformed into a COVID centre during the pandemic. Consequently, this required another approval from the ethical department in the MOH/ Kuwait. The process of getting another approval was a little stressful because email is not the main tool of communication in Kuwait. Furthermore, I was in the UK and in order to get approval from the MOH, I was required to be physically in the country. However, I travelled to Kuwait in October 2021 and managed to get the approval within a few days.

I was eager to focus on an area that has never been explored in my country. However, my background and experiences in working and dealing with people from the same profession were a little stressful. As a researcher I was looking at things differently, I was reflecting on my experience in the hospital where I found nurses as a victim of the health structure and system, and they have no voices. I assumed that executing this research in Kuwait would be less complicated and less time-consuming considering the focus was only on Kuwait. On the contrary, during the data collection process, the lack of participants from Kuwait was the main limitation. At this stage, I was aiming to follow the timeline set initially to conduct this research. Hence, with a lack of participants and time pressure, the discussion has been made with the supervisors to include more countries. The additional countries were decided to be Qatar, Jordan, and Egypt. This change was necessary to increase the scope of research hence being able to collect more data. Accordingly, it was more convenient to use semi-structured in-

depth interviews as a research method. Many research barriers have been managed by widening participation from additional countries. It also helped to communicate with participants from various geographical and cultural backgrounds to generate more diverse responses. Despite that, widening the participation encompasses more research in the literature and another ethical approval. Further, accessing the participants from the respective countries required flexibility concerning organising each interview with respect to participants' availability and adjusting the interviews according to their convenience. Some participants preferred to conduct the interviews during their night shifts, which is late, but I learned to be patient and flexible. Some participants frequently deferred the interview, hence, as a researcher I need to be agile and active in looking for other participants with coordinating with the MOH to collect sufficient data (more details will be provided in Chapter Three).

1.2. Study Background

Many patients are admitted to the hospital with problems related to skin integrity including wounds. In Kuwait, skin problem prevalence such as eczema and dermatitis are growing significantly which needs urgent intervention (Al-Haqan et al., 2012; Almutairi and Almutawa, 2017; Ziyab et al., 2023). The total number of females who are suffering from dermatitis in Kuwait is 58.91% (*ibid*). Further, chronic diseases such as Hypertension, Ischemic Heart Disease and Chronic Renal Failure are associated with post-operative wound infections in Kuwait (Alhubail et al., 2020; AlFawaz et al., 2022) and Qatar (Al-Mutawaa et al., 2022). Likewise, Abdel Jalil et al. (2017) stated that approximately 3 out of 20 women undergoing a caesarean operation in Jordan are suffering from surgical site infections. According to a study in Jordan by Saikal et al. (2020), a total of 79.8% of Syrian refugees complain of inflammatory skin conditions, and 33.84% suffer from dermatitis and eczemas. On the other hand, in Egypt, a total of 23.4% of children have a bacterial skin infection (Mostafa et al., 2012). In addition, skin infection, prevention and control practices need more improvement in Egypt (Metwally and Aamir, 2020). Based on Hussein, Almajran and Albatineh (2018), the prevalence of Diabetes Mellitus (DM) in Kuwait in 2013 was 23.09 %. Hence, the risk of diabetes adversely affects the skin texture and condition which could end with amputation. Christensen et al. (2019) and American Diabetes Association (2021) emphasised that skin problems are highly associated with DM. Ponirakis et al. (2020) highlighted that 23% of the population in Qatar have Diabetic Neuropathy. Another study performed by Al-Mutawaa et al. (2022) emphasises

the importance of enhancing community awareness about skin problems associated with chronic disease in Qatar. This could be achieved by developing specialised TVNs.

Over the years, nursing has evolved academically, professionally, and socially. For example, the transformation in the nursing role over the years from a care provider to a knowledge producer and educator. This is combined with the social process of defining and applying specialised knowledge in the real world which is known as professionalisation (Yagatich, 2018). In respect of this, Tissue Viability Nurses (TVNs) are independent nurses who specialise in tissue (Ousey et al., 2014). They aim to maintain skin integrity by reducing chronic wound risk factors and preventing skin inflammation or infection. The UK introduced the first TVNs in 1980, to overcome the issues of wound and skin integrity (Wounds-UK, 2014). Those nurses are leading doctors and other professions for effective change by introducing new knowledge and new approaches to managing wounds as well as improving the healing process (Kellie et al., 2010; Ousey et al., 2015). TVNs provide multiple valuable services related to wound management (Bryant and Nix, 2023). For example, assessment, evaluation, and diagnosis of skin conditions. Further, they are working independently to improve the care provided for patients by effectively contributing to the nurse-led speciality (Flanagan, 1998; Newton, 1999). The UK was used as a reference due to the lack of available data related to the TVNs role or wound specialist nurses in Kuwait, Qatar, Jordan, and Egypt. In the UK a total of 748 specialised TVNs are supporting the community by providing care for 87% of patients with wounds which shows their importance in supporting community health (Government-UK, 2018). However, Holloway and Bonifant (2019) argued that the TVNs role is limited to prevention and treatment while neglecting other aspects of wound care such as psychological status and social activity. Despite that Ousey et al. (2014), asserted that the role of TVNs is not limited to providing wound management only, but they have a vital role in cost-effectiveness by reducing the length of staying in the hospital alongside minimising hospital recurrent admissions for the same problem of skin. Through early detection of wound infection or skin problems to inhibit further complications and improve patient outcomes. Although, knowledge alone cannot assure the efficacy of TVNs. Sometimes the staff has the knowledge, but a lack of resources such as policies, guidelines, or materials; makes managing wounds more complicated which deteriorates the skin condition. Therefore, it is significant to understand why there is a lack of nurses' speciality in tissue viability in Kuwait, Qatar, Jordan, and Egypt, along with exploring the factors that affect the development of TVNs in the respective countries.

1.3. Research Problem

The wound has a negative impact on the individual and society. The complexity of the situation is increased when the patients have wounds associated with other problems such as Immune System Compromise, Peripheral Vascular Disease, and a history of amputation (Hess, 2011). Hay et al. (2014) stated that poor skin conditions are the fourth leading cause of nonfatal disease burdens globally. Further, Phillips et al. (2018), argued that the severity and types of wounds have a negative impact on patients, which could lead them to be socially isolated from others. For instance, patients with skin ulcers avoid meeting with others in order to protect their body image. Some skin diseases like eczema and skin rash are associated with severe anxiety (Pärna, Aluoja and Kingo, 2015). This implies that chronic wounds could increase the burden on health services. Also, Pleasant et al. (2011), emphasised that social perspective and culture have a significant impact on wounds and skin integrity. For instance, patients who receive social support attempt to have less stress (Palaya et al., 2018), which facilitates the wound healing process. Regarding cultural aspects, some people use homemade remedies or toothpaste to treat skin problems. Moreover, financial, and social status can negatively affect skin conditions (Klevens et al., 2007). As an example, people with low income cannot afford some medication to maintain a healthy skin condition, also being alone is significantly affecting skin conditions, especially for the elderly who need some support to clean and care for their skin. This indicates that wound management is a complicated process that requires individuals with specific knowledge and skills to provide efficient skincare and maintain skin integrity.

1.4. Significance of the Study

Nursing is one of the vocational professions, however, there is a lack of interest in nursing specialities (Finnell and Nehring, 2015). Several reasons impede the expansion of the TVNs in Kuwait, Qatar, Egypt, and Jordan as shown in Figure 1.4. The limitations associated with the nursing profession have been investigated in this research by using the theoretical framework of profession and professionalisation. Professionalisation is defined as a social process that demarcates status, knowledge, and occupational boundaries (Leigh, 2017). The process of professionalisation enables nurses to change their perceptions and roles, further, it increases their social status (Wall and Hallett, 2018). The professionalisation of nurses might contribute to developing the system and policy of skin integrity and wound management, which improves society’s trust in the profession. This involves understanding the profession from a different perspective by considering social, cultural, organisational, and political factors, that

play a role in changing the nurse's practice and enabling them to make decisions related to wound management and skin integrity. Developing a nursing speciality related to wound management could improve wound care in order to maintain healthy skin and wellbeing and to minimise the risk of further complications.

There is no empirical research conducted in Kuwait related to nurses' roles in wounds and skin integrity. This illustrates the knowledge gap in the role of nurses in Kuwait related to wounds and skin integrity. Further, there are limited published academic resources related to wound management and skin issues. In the case of Qatar, Jordan, and Egypt there is limited literature related to nurses' role in wound management. Hence, the current research explores the underlying phenomena. This study takes place in Kuwait, Qatar, Egypt, and Jordan; the selection of these countries is based on shared language, culture, geographical location, and other commonalities that will be explained later in this chapter. Moreover, it allows comparison and contrast between these countries. This is by exploring the actual status of nurses in these countries to understand the development of nurses' professional roles related to skin care and wound management. It also considers how the field of skin integrity has developed within the nursing profession. Additionally, this research will add new knowledge related to nursing, professionalisation and skin integrity which has not been explored before in a country such as Kuwait. This led to understanding the underlying reasons for the absence of TVNs.

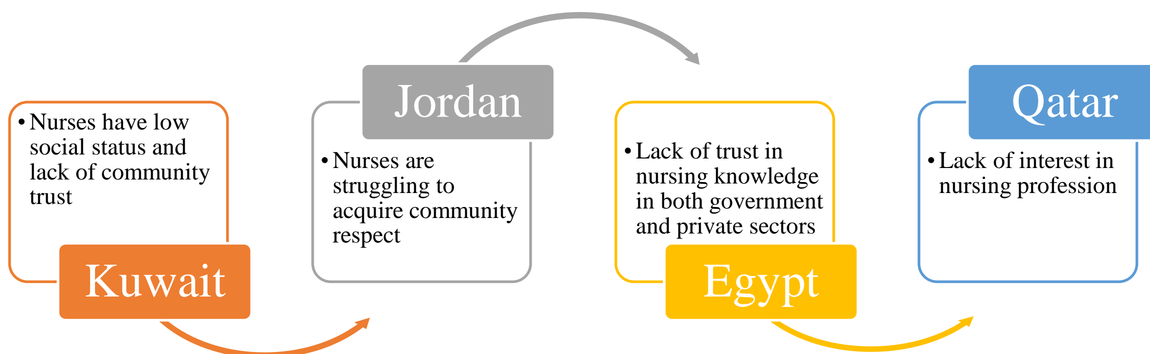


Figure 1.4: Reasons Impede the Expansion of the Nursing Speciality (Adib et al., 2002; Oweis, 2005; AbuAlRub, 2007; Elewa and El Banan, 2019; Tieleman and Cable, 2021).

1.5. Research Rational

Gjødsbøl et al. (2006) and Järbrink et al. (2017) described chronic wounds as one of the prominent public health problems that are commonly ignored by healthcare practitioners around the world. Yet, several studies and conferences were taking place internationally to discuss the issues related to skin integrity and wound management (Flanagan, 2013; Bryant and Nix, 2015). According to McGloin, Adam and Singer (1999), nurses are covering patients 24 hours, so they have more understanding of patients' conditions than other health professionals. Further, wound care is a basic part of nursing practice and care (Corbett, 2012). Considering the importance of nurses' role in maintaining a healthy life, by managing patients' health and avoiding health complications. If patients have chronic wounds and poor skin conditions, this adversely affects patients physical and psychological status. Hence, Tissue Viability Nurses (TVNs) are required to provide efficient wound care and enhance skin integrity. Despite that, in Kuwait the area of wound management and skin integrity is underexplored. Moreover, no research related to nurses’ role in skin integrity and wound management has been conducted. Therefore, this research uses a professionalisation framework to provide a clear framework with a defined scope of knowledge for nurses to enhance their practice and provide consistent and effective wound care. Kuwait spent a substantial amount on renovating hospitals and introducing new quality programmes, to improve the health services. However, there is no significant investment in the nursing profession, and there is a lack of nursing specialities in Kuwait. Further, this research dissemination could help to deliver the information related to the issues to the decision makers to increase their awareness of the issues related to the nursing profession, which need their intervention.

In a social context, this research attempts to understand human behaviour, and their relationships and interactions within the system and society, this encompasses social inequality and social norms, culture and cultural diversity, and organisational structure (Burke et al., 2009; Risman, 2018). This also brings together the context to understand the individuals within public health and to improve human health and well-being. Public health aims to improve community well-being by preventing and controlling chronic diseases, which could affect skin conditions and the wound healing process. Therefore, applying social sciences knowledge to public health would contribute to identifying social and cultural factors that influence health and well-being, such as socioeconomic status and social norms and practice. This helps to develop the interventions and policies that enable nurses to lead in the area of wound management in

Kuwait, Qatar, Jordan, and Egypt. To improve health outcomes through resolving conflict and understanding fear associated with changing the context of the system or changing the role of nurses and empowering them for decision making. This manifests that the social sciences and public health are connected and working together to improve community health and well-being, but their areas of focus might differ depending on the research question.

1.6. Research Aim, Objectives, and Questions

This study aims to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity in Kuwait, Qatar, Jordan and Egypt, by understanding the concept of professionalisation related to nurses and skin integrity.

1.6.1. Objectives

1. To understand the influences of developing specialist nurses in tissue viability in Kuwait, Qatar, Jordan, and Egypt.
2. To explore the challenges of the development of specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt.
3. To discuss the feasibility of developing specialist nurses in tissue viability from different perspectives, through the decision makers (policymakers in the Ministry of Health, hospital directors and director of the nursing directorate) and gatekeepers (general/specialised nurses, nurses-team leaders, head nurses, nursing assistant director, nursing director and doctors).
4. To provide recommendations on how tissue viability nurses, as specialist nurses are feasible in Kuwait, Qatar, Jordan, and Egypt.

1.6.2. Questions

1. What are the contextual factors that affect the development of speciality nursing in tissue viability in Kuwait, Qatar, Jordan, and Egypt?
2. What are the barriers and facilitators to developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt?
3. Is the professionalisation of nursing an opportunity for developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt?

1.7. Background of Kuwait, Qatar, Jordan, and Egypt

The researcher belongs to Kuwait along with gaining work experience from the same that justifies the selection of Kuwait. Qatar has been chosen as a part of the Gulf Cooperation Council (GCC), further, considering culture, tradition, religion, and socio-economic similarities. Both countries are economically prosperous due to their Oil and Gas resources. These similarities help to develop some understanding of the system and the way it shapes the nursing profession. Additionally, the selection of Jordan and Egypt is due to similarities in language, culture and health system as shown in Figures 1.5 and 1.6 along with Table 1.1. All those countries were under British protection, therefore, there are similarities in their healthcare structure and system. Moreover, expanding the scope of this research broadened the understanding of the issues that nurses are facing regarding their practice, particularly in skin integrity and wound management.

Figure 1.5: Location of Kuwait, Qatar, Jordan, and Egypt on the Map

Table 1.1: Key Facts of Kuwait, Qatar, Jordan and Egypt (Casey, Thackeray and Findling, 2007; Achilli, 2015; Cordesman, 2018; Difi, 2022; Seshan, 2012)

Country	Location	Socio-economic	Political system	Beginning of Nursing
Kuwait	-Independent emirate Between Iraq and Saudi Arabia	-Economic freedom score 58.3 -Rapid socio-economic development in the past four decades.	-Under British protectorate (1882-1961) -A constitutional monarchy with a parliamentary system of government. The ruling Al-Sabah family holds executive power, but the parliament has a significant role in decision-making. Kuwait has a relatively open political system.	-Nursing school 1962. -Nursing Association 1991.
Qatar	-Independent emirate on the west coast of the Persian Gulf.	-Economic freedom score 67.7 -Rapid socio-economic development.	- Under British protectorate (1916-1968). -Constitutional monarchy ruled by the Emir, who has broad powers to appoint government officials and enact laws. -The country has a relatively liberal political environment and has been reforming its political system.	-Nursing school 1965. -Nurses Association 2014.
Egypt	-North-eastern corner of Africa.	-Economic freedom score 49.1 -Socio-economic inequalities and instabilities.	-Occupied by The United Kingdom (1882-1945). -Democratic Republic with the President as the head of state and the Prime Minister as the head of government. -Egypt has a history of authoritarian rule and political freedoms and civil liberties are limited.	-Nursing school 1952. -Nurses' Union 1976.
Jordan	-Bounded to the north by Syria, to the east by Iraq and south by Saudi Arabia and to the west by Palestine and the West Bank.	-Stressed economic and social situation conflicts due to neighbourhood and regional dynamics. -Economic freedom score 60.1	-A mandate of the United Kingdom (1918-1946). -Constitutional, hereditary monarchy with the King as the head of state and the Prime Minister as the head of government. with a multi-party-political system and the parliament has significant legislative power.	-Nursing school 1953. -Nurses' Union 1972.

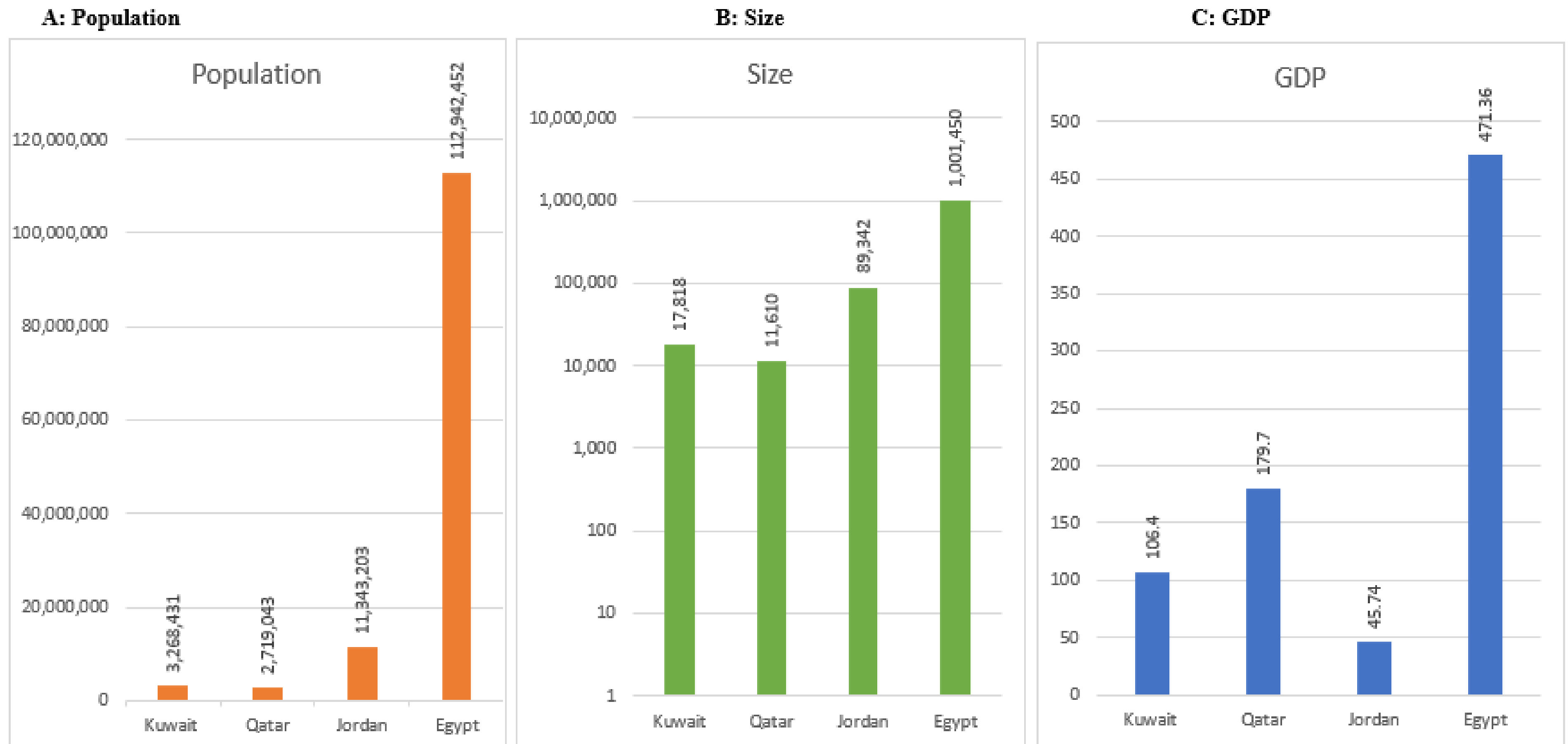


Figure 1.6: Key Facts about Kuwait, Qatar, Jordan, and Egypt (World Meter, 2020a, b, c, d, e; Trading Economics, 2019a, b, c and d)

1.7.1. Kuwait Profile

Kuwait is located in the Middle East, and it is part of the Gulf Cooperation Council (GCC) as shown in Figure 1.7. The country is known for its semi-democratic political system where the power is divided between the royal family and the Kuwait parliament (Segal, 2021). The country remains neutral in the regional conflicts pertaining to geopolitical position and geostrategic location as given in Figure 1.5. This led the royal family of Kuwait to be under the British protectorate from 1899 till the country achieved its independence in 1961 (Casey, Thackeray and Findling, 2007; Cordesman, 2018). The latest census shows the population is distributed between 1.128,381 million Kuwaiti nationals and the remainder non-Kuwaiti nationals as given in Figure 1.8 (Kuwait government online, 2012).

Figure 1.7: GCC (Argaam, 2020)

According to WHO (2016), the literacy rate for the young generation between 15 to 24 years is 98.8% and for adults, more than 24 is 95.5%. The official language in Kuwait is Arabic despite that, the English language is commonly spoken in the country (Hussein, Almajran and Albatineh, 2018). Further, the vast majority of the population is comprised of Muslims (74.6%), 18.2% of the population is Christian and 7.2% of the population has different religions (*ibid*). Concerning religions, the Kuwaiti constitution preserves all citizens and residents the freedom to practise their religion by providing places of worship for the heavenly religions. Besides, the government considers the employees during their religious days such as Aid for Muslims and Christmas for Christians. The Ministry of Health in Kuwait aims to promote health and provide high-quality services (Salman et al., 2020). This is reflected in the distribution of nurses among the hospitals and clinics considering their qualifications and skills. In chapter two more details are provided about the nursing profession in Kuwait.

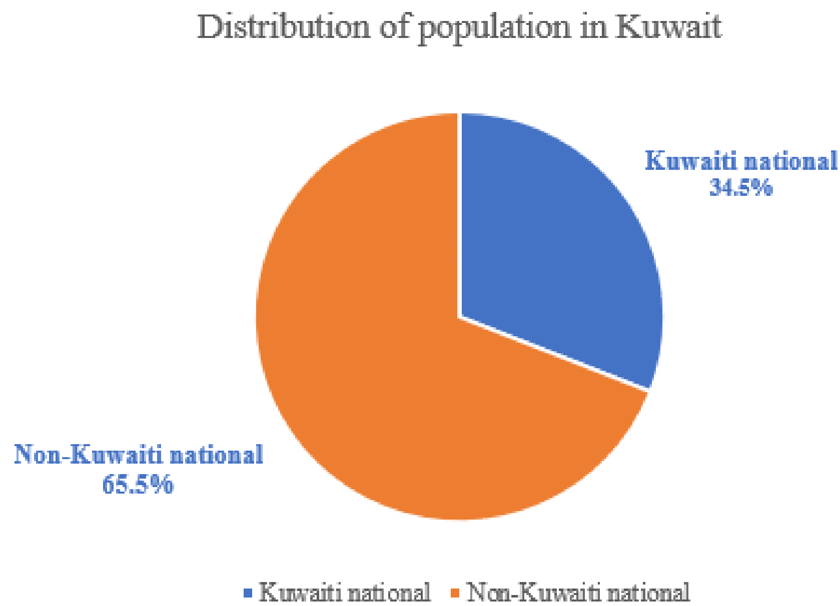


Figure 1.8: Kuwait's Population Distribution (Statista, 2023b)

The healthcare system in Kuwait is divided across the country among six health regions each of which provides health services for about 300,000 patients, based on their location which is distributed as shown in Figure 1.9. Those health regions include a public general hospital, and several community health centres/polyclinics divided according to the area's needs. All referrals for health specialists are sent to the Sabah Public Health Regions where more than 17 Health Centres are available such as given in Table 1.2. To understand the healthcare system in Kuwait, it is important to see how the health hierarchy is designed as shown in Figure 1.10. The Ministry of Health in Kuwait is the main governing body that is responsible for delivering health facilities for the population such as polyclinics, hospitals, and ambulance services.

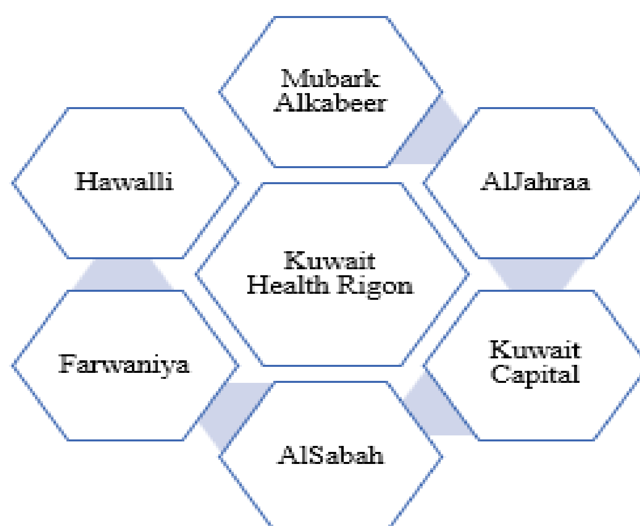


Figure 1.9: Kuwait Health Region (Ministry of Health / Kuwait, 2021)

Table 1.2: Health Speciality Centres in Kuwait

No.	Health Centre	Speciality
1.	Ibn-Sina	Nerve
2.	Al-Bahar	Eyes
3.	Zain	Ear-Nose-Throat
4.	Al-Sadr	Heart
5.	Al-Daran	Lung
6.	Hamed Al-Essa	Renal Disease
7.	Al-Nafisi	Renal Dialysis
8.	Sabah Al-Ahmed Urology Centre	Urology and Infertility
9.	Maternity Hospital	Gynaecology and Maternity
10.	Al-Razi	Fracture
11.	Dermatology Centre	Skin
12.	Al-Rashid Centre	Allergy
13.	Maki Jomaa	Tumour and Cancer
14.	National Kuwait Bank Centre	Blood Disease
15.	Al-Bab tin	Burns and Plastic Surgery
16.	Islamic Centre	Remedies
17.	Palliative Centre	Palliative care

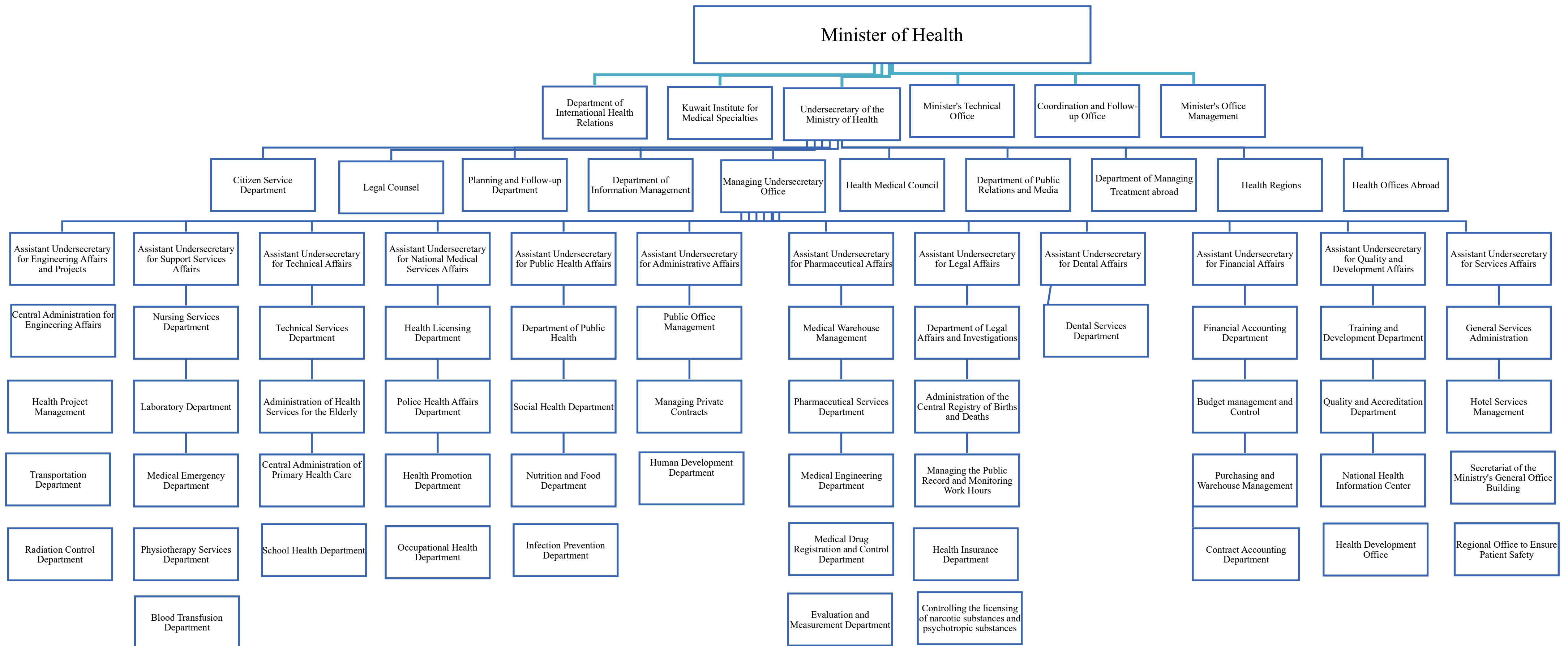


Figure 1.10: Health System Structure in Kuwait adopted from the Ministry of Health Kuwait hierarchy (Ministry of Health / Kuwait, 2022)

The health region is considered to be a decentralised administrative organisation that comes directly after the Ministry of Health and aims to deliver the main administrative work for the employees within the particular health region for the sake of reducing the pressure on the Ministry of Health. Each health region has three categories: primary, secondary, and tertiary, all collaborating to provide the best services for the patients. For example, 157 dental clinics, as well as 74 Primary Health clinics, provide community healthcare services (Nazar, Ariga and Shyama, 2022), this is identified as providing minor services that do not require medical or surgical interventions such as non-complicated wound dressing and vaccination (W.H.O, 2006). Moreover, six general hospitals are divided into health regions that provide tertiary-level care for 24 hours such as medical, surgical and paediatrician. In addition, different specialised centres are distributed throughout the country. There are a total of 17 centres such as maternity and urology (ExpatFocus, 2017). The health care system in Kuwait is at par with the other GCC. The health services in the government sector of Kuwait are free for the citizens. A citizen can access any primary or secondary health services based on the regional facilities. Conversely, non-Kuwaiti nationals have to pay for health insurance along with other fees every time they access government health services. This new rule was introduced by the Ministry of Health in 2016 to reduce the workload on government hospitals and distribute the patients between the private and government sectors (Gulf Business, 2017).

1.7.1.1 Development of the Health System in Kuwait

Kuwait like other countries where people in the past were not enjoying medical services such as clinics or hospitals, focuses on applying ancient methods like herbs and remedies to cure disease, cauterisation for stomach pain or wounds, “kohl” which is a specific form of Arabic eyeliner applied to treat conjunctivitis. It is common for Kuwaiti people from the old times till now to read from the Holy Quran “Al-Fatihah” along with making prayers and sacrifices to the Holy God to relieve their pain. However, those ancient methods were not enough to cope with some health conditions and epidemic diseases. For instance, a large number of Kuwaitis died due to the “Plague” in 1831, apart from that, smallpox, tuberculosis, whooping cough, syphilis, measles, and other diseases. The development of the health system in Kuwait began in 1910 when the first medical clinic was established by the British. After performing some surgeries, this clinic aimed to increase people's trust in the health services, hence the clinic was transferred to a hospital. Despite that, the first hospital in Kuwait was established in 1947 by the British and Americans who worked for Kuwait Oil Company (Kuwait Oil Company, 2021). The first hospital is shown in Figure 1.11. Amiri Hospital was

the first government hospital in Kuwait with a 45-bed capacity opened in 1949 (The Kuwait Ministry of Health, 2022). A few years later, the health sector developed significantly after the country achieved its independence from British protection. Following that, another governmental hospital with a bigger bed capacity was funded in 1962, and from that time till now the health system in Kuwait changed fundamentally (*ibid*).

Figure 1.11: First Hospital in Kuwait (Kuwait Oil Company, 2023)

Kuwait is known for its wealth derived from substantial oil resources; the GDP is $106.4/ billion (Trading Economics, 2020). The financial resources facilitate the country to develop and invest dramatically in social welfare projects such as hospitals, and other government organisations and for overall infrastructure development as shown in Figure 1.12.

Figure 1.12: Kuwait Social Welfare Projects (Sattout, 2019)

In line with developed countries such as the US, UK and Japan, Kuwait aims to develop healthcare services by investing effectively in welfare projects to promote healthcare services and deliver the best care for patients. Ikegami (1988) and Asia Pacific Observatory on Health Systems and Policies (2018) stated that Japan's welfare has played an essential part in developing healthcare services in the country. This assists Japan in using the highest technological devices in health organisations which improves the health services effectively (Kramer et al., 2014). Furthermore, Parente and McCullough (2009) stated that technology has a significant impact on health system growth. This shows the importance of welfare and technology in developing the healthcare system in the country. This influences Kuwait to invest in advanced technology to improve health standards such as using advanced programs and machines for managing data or treating patients such as in Kuwait Scientific Centre, Jaber Al Ahmed Hospital and Sabah Al Ahmed Urology Centre (Al-Diwan Al-Amiri, 2013; Al-Ghanim international, 2013). Kuwait is one of the first countries in the Middle East that use Robots for specific types of surgery and procedures such as removing tumours (Arab Times, 2013). Different studies have proved that wealth and resource utilisation assist the country in development. Regardless, there is a fear of technology that can replace health personnel such as Robot nurses in Japan (Asia Pacific Observatory on Health Systems and Policies, 2020). Yet, there is no clear evidence that welfare and advancement in technology have a negative impact on health services, but it is worth considering the last point in future planning strategies.

Kuwait set a vision for 2035 that aims to improve the quality of healthcare services by investing in scientific research and applying advanced technology and the progress towards this as shown in Figure 1.13 (Salman et al., 2020). As a result of this initiative, foremost the healthcare facilities of the country will come at par with the other countries of the region and the role of the nursing profession will be improved as well as will become an integral part of healthcare facilities. The strategic plan of the country aims to introduce significant progress in community services and health welfare (El-Katiri, Fattouh and Segal, 2011). This led the life expectancy to increase from 50 years to 75 years over the past 5 decades, which reveals that the healthcare system has improved in the country (Our World in Data, 2019). Although the significant improvement in life expectancy in the community care services for non-communicable diseases needs more improvements. Consequently, the country has a higher rate of adult obesity within the region along with diabetes and cardiovascular diseases (Salman et al., 2020). Based on the strategic plan of Kuwait, the MOH provides home visit services for those unable to go to clinics to provide comfort for patients and satisfaction.

Figure 1.13: Kuwait's Investment in Healthcare Services (Warrier, 2019; Gulf Consult, 2021; Esra, 2019)

Salman et al. (2020) claimed that Kuwait's healthcare system is not reliable, and the country relies significantly on medical tourism or reliance on other countries for better healthcare treatments. Al-Hendi, Al-Saifi and Khaja (2020) stated that a lack of trust in the medical services in Kuwait drives Kuwaiti citizens to seek medical treatment outside the country. Lack of trust comes from various reasons, one of these reasons could be a lack of speciality in some areas such as a lack of wound specialists. This makes the Kuwaiti government struggle between improving individuals' perception of health services and investing in healthcare projects. Eventually, individuals' perceptions of the healthcare system will be improved after experiencing new changes and different health strategies. In this context, developing a new strategy related to skin and wound management in Kuwait might be useful to facilitate nurses to act effectively within their professional roles and responsibilities, which would improve the healthcare system. Based on the research conducted by Mossialos et al. (2019) at the London School of Economics and Political Science, highlighted that the state of Kuwait aims to avoid external reliance, this could be achieved only by changing the entire healthcare system, by introducing new policies or amendments to the existing policies, also,

the treatment facilities should be changed in a way to meet the local demands and fulfil patient's need. Therefore, this will include improving the quality of the community/primary, secondary and tertiary healthcare services in the country. In this regard, the next paragraph explains how the Kuwaiti government introduced a new accreditation programme to enhance the quality of the health system.

1.7.2. Qatar Profile

Qatar is part of the Gulf Cooperation Council (GCC), see Figure 1.14. bordered by Saudi Arabia to the south and from north, east and west surrounded by the Arabian Gulf (Statista, 2023c). It is located in the Middle East, on the north-eastern coast of the Arabian Peninsula as shown in Figure 1.5. The country is relatively small; however, it is playing an important role in regional and international affairs. The country is ruled by the Emir of Qatar, who serves as the head of state and government. Prior to the current regime, it was ruled by the Ottoman Empire from the late 19th century to the early 20th century (*ibid*).

Figure 1.14: GCC Union
(Muslim Mirror (2023)

After that, the country was under the British protectorate till its independence in 1968. Initially, the country was settled by a small group of Bedouins from the central part of the Arabian Peninsula. This is due to its vast reserves of natural gas and oil (Statista, 2022), which have transformed the country from a small desert state into a major economic power in the region. The Qatari citizens represent a small portion of the total population of Qatar (Al-Ghanim, 2009). According to Expatica (2023), the total number of Qatari and non-Qatari nationals for 2023 is represented in Figure 1.15. The Qatari government set a plan to recruit employees from outside the country to fulfil the shortage of human resources in all areas. Since its independence and economic growth, the country relies significantly on foreign labour, mostly from India which covers 20%, Nepal 13%, Philippines 10%, and Pakistan 7% (Goodman, 2015). Furthermore, 20% of the workforce includes expatriates from the Arab

world mainly Egypt, Jordan, Palestine, and Iraq (Sukkan, 2016). According to Statista (2023c), the literacy rate in Qatar between the age of 15 and above for the year 2017 was around 93.46 %. The Arabic language is the official language in Qatar and English is widely spoken. Similar to Kuwait, Qatar's culture, religion, and language are deeply intertwined and reflect the country's unique history and traditions. Islam is the predominant religion in Qatar, with around 95% of the population being Muslim and the remaining are different religions. The country follows Islamic values and practices in daily life. Further, the culture is heavily influenced by Bedouin traditions along with Islamic values. Traditional Qatari clothing includes the thobe, a long, loose-fitting garment worn by men, and the abaya, a black cloak worn by women. Further, all expatriates in Qatar are free to wear their national dress and practise their religion.

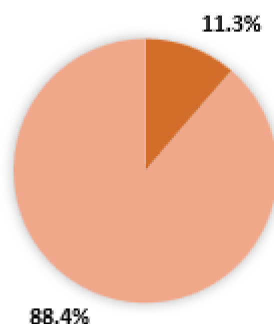


Figure 1.15: Distribution of the Population in Qatar

The role of women in Qatar has been evolving in a positive direction in recent years, and they are increasingly becoming a vital part of the country's development and success. Women’s roles are increasing significantly in Qatar society, particularly in the areas of education, healthcare, and business (Al-Ghanim, 2009), especially after winning the right to vote in 1999 (Suliman et al., 2018). This demographic change related to women’s rights enabled women to incorporate more within society. Women have been encouraged to participate in the workforce as part of the country's efforts to diversify its economy and reduce its reliance on oil and gas. Women are also represented in the workforce, with many holding leadership positions in various sectors, especially the health and education sectors. In recent years, the Qatari government has introduced a number of policies to support women's rights and encourage their participation in the workforce (Golkowska, 2014). For example, there are

laws prohibiting discrimination based on gender and women are entitled to the same legal rights as men.

1.7.2.1 Development of the Health System in Qatar

Qatar has a well-developed healthcare system that is equipped with advanced technologies to provide high-quality health services to its citizens and residents. The country has made substantial investments in its healthcare infrastructure and facilities, with the aim of becoming a regional hub for medical tourism (Goodman, 2015) Some of the recently developed healthcare facilities are shown in Figure 1.16. The healthcare system in Qatar is predominantly operated by the government, through the Ministry of Public Health. It oversees the management of all public healthcare facilities in the country, including hospitals, primary care and speciality clinics. There are also a number of private healthcare providers operating in Qatar, which provide to both citizens and international patients. The healthcare services provided in Qatar are generally of a high standard, with modern facilities and well-trained healthcare professionals (Alshamari, 2017). The country has a high doctor-to-patient ratio, and it also has a comprehensive health insurance system, which covers all citizens and residents of the country. The government provides basic health insurance coverage to all citizens and residents, while private health insurance is also available for those who wish to access additional services.

Qatar's healthcare system places a strong emphasis on quality, safety and patient-centred care (AlQahtani, 2016). The country has made significant investments in healthcare infrastructure, technology, and human resources to deliver high-quality healthcare services in the country. The Ministry of Public Health in Qatar is responsible for implementing quality programs and ensuring that healthcare facilities and professionals meet the necessary standards. Qatar aims to achieve the goal of the National Vision 2030, which is a long-term development plan that includes several goals related to healthcare. The vision aims to elevate the standard and quality of healthcare services in the country and enhance the skills and knowledge of healthcare professionals (Elsayed, Abdullah and Aboulsoud, 2018). The Qatar Council for Healthcare Practitioners (QCHP) sets standards for education and professional development and further provides ongoing education and training opportunities for healthcare personnel (*ibid*). Moreover, the country also invested in medical research and education to improve the quality of services by introducing quality programmes such as Joint Commission International (JCI) and Accreditation Canada (Suliman et al., 2018), these are given in Table 1.3. The healthcare system in Qatar has undergone significant development over the past few decades.

Therefore, country has been redefining policies and strategies towards building a remarkable healthcare system (Wadoo et al., 2021). However, there are challenges and areas for improvement, including the need to address rising healthcare costs and improve access to healthcare services in some parts of the country (Goodman, 2015). One of the key developments in the healthcare system in Qatar is the establishment of the Hamad Medical Corporation (HMC) in 1979, which is now the main provider of public healthcare services in the country as shown in Figure 1.17 (Wadoo et al., 2021). HMC is a non-profit organisation that operates several hospitals and healthcare centres in the country. Qatar has also established a National Health Insurance Scheme (NHI), this scheme aims to elevate health services by providing health insurance coverage to all residents of the country. The NHI aims to provide affordable and accessible healthcare services to all residents, regardless of their income level. Apart from that, the country has invested heavily in the healthcare sector, to provide high-quality healthcare services to its citizens and residents.

Figure 1.16: Sidra Medical and Research Centre (2023)

Figure 1.17: Hamad Medical Corporation (2023)

1.7.3. Jordan Profile

Jordan is a major producer of phosphates, which is a key export, the economy is relatively diverse and relies on industries such as tourism, pharmaceuticals, and information technology. However, it faces a number of challenges, both internal and external. Some of the major challenges facing the country include regional instability as the country is located in a volatile region that has been affected by conflicts in neighbouring countries, such as Syria and Iraq (Achilli, 2015), as shown in Figure 1.18 It is considered as a Muslim country, with about 95% of the population identifying as Muslims (US Department of State, 2022), and Christians are minorities. Islam has a significant influence on Jordanian culture, with many traditions and customs rooted in the religion. In the same line with Kuwait and Qatar, Jordanian culture is also influenced by Bedouin traditions, with many Jordanians maintaining strong ties to their tribal roots.

Figure 1.18: Jordan Map

1.7.3.1 Development of the Health System in Jordan

Jordan has made significant progress in the development of its healthcare system over the past decades. The country has invested in healthcare infrastructure and services and the healthcare system in Jordan is relatively well-developed. The Ministry of Health oversees the public healthcare system, which provides basic healthcare services to the population at a minimum cost or free of charge. Private healthcare providers also operate in the country, offering a range of services, from basic primary care to specialised treatments. The government and private healthcare services have been expanded to rural areas of the country (Nazer and Tuffaha, 2017). The government has established health centres and clinics in these areas as well as provided financial incentives to healthcare providers to work in these locations. These health centres and clinics are offering a range of services and treatments to patients. This has helped to improve the access to healthcare services for people living in remote and rural areas and has contributed to better health outcomes and quality of healthcare. This leads to increased competition in the healthcare market leading to better outcomes for patients.

The healthcare system in Jordan has made significant progress in recent years, with improvements in access to healthcare services and a reduction in mortality rates for major diseases such as cardiovascular disease and cancer (El-Jardali and Fadlallah, 2017). Jordan has made significant investments in medical education and training (*ibid*). The country has established several medical schools and universities and has a well-trained and qualified workforce of doctors, nurses, and other healthcare providers (Al-Ja'afreh, 2019). This has helped to build a strong and qualified healthcare workforce in Jordan and has contributed to the high standard of care provided in the country. However, there are also challenges facing the healthcare system in Jordan, including a lack of funding and limited resources. Despite these challenges, the healthcare system in Jordan continues to provide important services to the population and the government has made efforts to improve access and quality of care. It also attracts a significant number of medical tourists, who come for specialised treatments such as fertility treatments and cosmetic surgery (Connell, 2006).

1.7.4. Egypt Profile

Egypt has a rich history and culture, which is reflected in its religion, demographics, and customs. The majority of the population in Egypt practises Islam as 90% is Muslims. There are also significant Christian and Jewish populations in the country, with the Coptic Orthodox Church being the largest Christian denomination. The official language in Egypt is Arabic. In modern times, Egypt has faced many challenges, including political instability and economic struggles. However, the country is still an important cultural and economic hub in the Middle East and Africa. Tourism is a major industry in Egypt and the country is considered a major producer of cotton and is known for its agricultural exports, including fruits and vegetables.

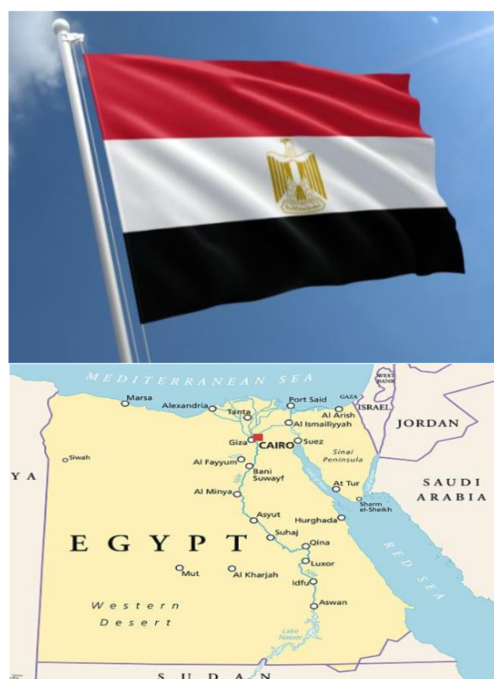


Figure 1.19: Egypt Map

The Suez Canal, connects the Mediterranean and Red Seas, it is a crucial shipping route and a major source of revenue for the country, see Figure 1.19.

1.7.4.1 The Development of the Healthcare System in Egypt

The healthcare system in Egypt has undergone significant changes and developments over the years. It was started by the ancient Egyptians, who were known for their advanced medical practices, such as mummification and surgery; their medical knowledge was documented in texts (Allen, 2005). Then in the early 19th century, the ruler of Egypt Muhammad Ali Pasha initiated modernisation efforts, which included the establishment of hospitals and the training of doctors. In the early 20th century, the government established a public healthcare system to provide healthcare services to all citizens. The system was based on a network of primary care clinics, district hospitals and regional hospitals (*ibid*). Followed that the country launched a national health insurance system in 1964. The system was financed by a combination of taxes, employer contributions and individual contributions. In 1990, a series of health sector reforms had been introduced to improve the quality of healthcare services and to increase efficiency. The reforms included decentralisation of the healthcare system, strengthening of the primary care system and introduction of patient fees.

Egypt has made progress in expanding access to healthcare services and improving the quality of care. The government has invested in infrastructure, equipment, and human resources, and has launched initiatives to address key health challenges such as communicable and non-communicable diseases, child and maternal health and other challenges. Egypt's healthcare system involves public and private sectors, and the Ministry of Health is responsible for managing public and private healthcare services. Public healthcare is provided through a network of hospitals and clinics, including general and specialised hospitals, outpatient clinics and rural health units. These services are provided for free or at a low cost to the citizens. However, the quality of healthcare services in the public sector varies, with shortages of medical supplies and equipment, as well as inadequate staffing in some areas (Eskander, Morsy and Elfeky, 2013). In contrast, private healthcare services are generally higher in quality and provide more advanced medical treatments than the public sector (Haddad and Fournier, 1995). However, private healthcare services can be expensive and may not be affordable for all Egyptians (Brugha and Zwi, 1998). Despite the developments of the healthcare system in Egypt, the challenges remain, including inadequate healthcare funding, several resignations, and inequalities in healthcare services access between urban and rural areas (Abd-Allah and Moustafa, 2014). Further, many hospitals and healthcare facilities in Egypt have outdated infrastructure and inadequate resources, which can create a challenging working environment

for nurses (*ibid*). This can include issues such as overcrowding, lack of necessary medical equipment and supplies and inadequate staffing levels.

1.8. Accreditation and Quality Programme in Kuwait, Qatar, Jordan and Egypt

Enhancing health services and improving patient outcomes is one of the main priorities of the strategic plan of the Ministries in Kuwait, Qatar, Jordan, and Egypt. In this perspective to achieve these goals, the M.O.H. established an accreditation programme in Kuwait (Alhaleel, 2018). Kuwait adopted the Canadian Accreditation Programme to improve the quality of health services and change the entire health system (Al Hamid, Malik and Alyatama, 2020), likewise in Qatar, Jordan, and Egypt, this is shown in Table 1.3. The Accreditation Department provides its services for patients in collaboration with the M.O.H (Alkhenizan and Shaw, 2012). The Accreditation and Quality Programme / Canada are an independent, non-governmental organisation, allied to the Health Standards Organisation. It relies on licensure, certification and accreditation based on a 5 year cycle (Natarajan, 2006). Further, it works directly with the patients, society, stakeholders and decision-makers such as hospital directors and people in managerial positions in the health ministry, to deliver high-quality health and social services for all (School Oral Health program, 2021). The sample of the certificate given by this accreditation is given in Figure 1.20, further, Table 1.3 shows the year in which the Accreditation and Quality Programme started in Kuwait, Qatar Jordan, and Egypt. Healthcare quality is related to providing safe, equitable, efficient, and effective health services to all users (Plsek, 2001). Therefore, these initiatives of quality programmes in the respective countries could facilitate the development of TVNs to improve the quality of service. Also, the nurse's role related to managing wounds and skin integrity is considered a quality indicator (Lichterfeld-Kottner et al., 2020; Seaton, Cant and Trip, 2020). However, getting into the accreditation process requires specific infrastructure and some facilities that are not available in some organisations (Katoue et al., 2021). Further, some problems exist related to the lack of human resources, policies, and guidelines (*ibid*). Also, the appropriate allocation of resources such as human resources and provision of time to become familiar with the new programme is a limitation for effective implementation (Ghobashi et al., 2014; Mathieson, Grande and Luker, 2019).

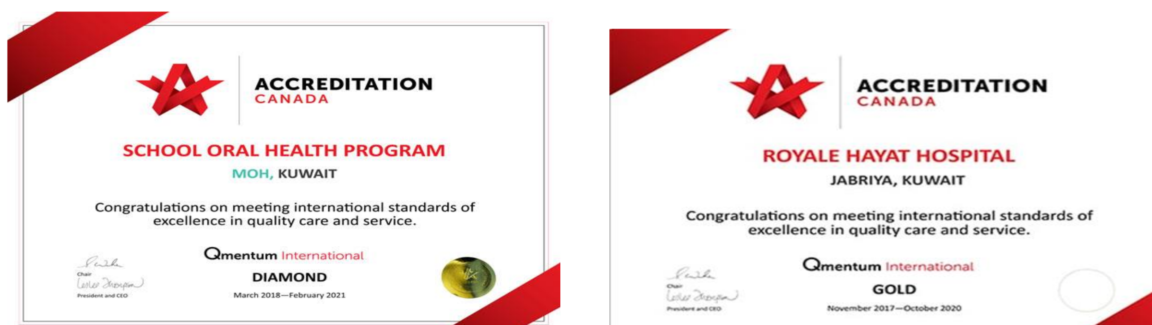


Figure 1.20: Accreditation Canada for Governmental and Private Health Sectors (School Oral Health Program, 2021).

Table 1.3: Accreditation and Quality Programme in Kuwait, Qatar, Jordan and Egypt

Country	Quality Programmes
Qatar	In 2015, Hamad Medical Corporation (HMC), which is the main healthcare provider in Qatar, implemented the Accreditation Program to enhance the excellence of healthcare services in the organisation (Suliman et al., 2018; Hamad Medical Corporation, 2023).
Kuwait	In 2010, the Ministry of Health in Kuwait introduced the International Accreditation Programme in collaboration with Canada, to improve health services and provide better care based on national standards (Quality and Accreditation Directorate Kuwait, 2010; AlFadhala, Elamir and Helmy, 2020).
Jordan	In 1999, Jordan implemented the Jordan Healthcare Accreditation Project to improve the quality of healthcare services (Shamieh et al., 2020).
Egypt	In 1991, the Gold Star Quality Programme was established, which aims to improve the quality of healthcare services in Egypt (Ishijima et al., 2019; Bassiouny and Elhadidy, 2022).

1.9. Thesis Structure

This thesis is divided into six chapters as given in Table 1.4.

Table 1.4: Thesis Structure

Chapter	Chapter context	Details
Chapter One	Research Introduction	This chapter provides brief information related to the research context, background, significance, and rationale. Further, it encompasses the Kuwait, Qatar, Jordan, and Egypt profiles, research aim, objectives, and questions.
Chapter Two	Literature review	In order to answer research questions and achieve the research aim and objective, this chapter includes a critical literature review related to the research topic. This literature review considered: profession and professionalisation concepts, along with the challenges and opportunities of professional development. Further, an overview of nursing development including TVNs and nursing in the respective countries.
Chapter Three	Methods and Methodology	This chapter brings together the research design, tools, and data collection process. Further, exploratory qualitative methods were applied to provide insight and richness of understanding of the situation related to the absence of specialisation of wound management and skin integrity, through the lens of professionalisation of nurses in Kuwait, Qatar, Jordan, and Egypt.
Chapter Four	Findings and Analysis	Thematic analysis was used to present the findings. The findings have been keenly focused on the responses of interviewees that are thematically analysed.
Chapter Five	Discussion	This chapter includes a discussion of the findings, the implications of the research, and the contribution to the knowledge and methodology.
Chapter Six	Conclusion and Recommendation	This chapter summarises the entire research and provides a conclusion along with the research strengths and limitations, further, recommendations for the future.

1.10. Summary

This chapter set the tone for the rest of the research, by providing information related to the research background, context, and rationale for undertaking this research. Further, the research aim, objective and question are discussed in this research. Additionally, an overview of Kuwait, Qatar, Jordan, and Egypt; profiles and healthcare systems have been provided.

CHAPTER TWO
LITERATURE REVIEW

2.0. Introduction

This chapter was conducted to develop an understanding of the research topic, by exploring a range of literature related to this study. This will serve two purposes first getting familiarised with the topic and identifying the knowledge gap in the literature related to the topic and how this helps in formulating and strengthening the research questions; to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity in Kuwait, Qatar, Jordan, and Egypt. Therefore, this chapter explores and discusses the literature to provide detailed information about the profession, professionalisation, TVNs, and skin integrity. Specific consideration was given to the existing literature related to the nursing profession, TVNs, and wound management in Kuwait, Qatar, Jordan, and Egypt. To facilitate understanding of the concept of professionalisation related to nurses and skin integrity and how this affects wound management and the role of TVNs. In addition, this chapter considers the organisational, social, cultural, political, and other contextual factors that influence the development of the nursing profession and wound management in that region.

The literature review is a continuous process of assessing, reading, analysing, and reviewing academic and scholarly resources related to the topic (Kabir, 2016). It can be conducted systematically (sequential steps to evaluate the quality of the literature) or unsystematically (comprehensive narrative of previously published data) (Pautasso, 2019). This research used a narrative literature review, it is a traditional way of conducting the literature review and performs to enhance the interpretation of previous knowledge, hence, it is commonly used in qualitative research (Sylvester, Tate, and Johnstone, 2013) humanities and Social Science (Morris et al., 2013). In order to enhance the value of the data, the narrative review encompasses data synthesis related to a particular topic through searching, reading, and evaluating the literature, then selecting relevant ones to the topic which increases the rigour of data. Consequently, the value of a narrative literature review lies in the rigour of the data. This in return highlights significant issues as well as increases the researcher's background information about the topic, to facilitate understanding (Lau and Kuziemsky, 2016), further identifying the knowledge gap (Green, Johnson, and Adams, 2006). Therefore, this research

tends to identify the knowledge gap related to the lack of research related to wound management in Kuwait, Qatar, Jordan, and Egypt and the lack of specialisation of nurses in those countries. Also, considering this research is a social science and public-health oriented (Chapter One, Section 1.5.), then applying a narrative literature review in this research will be more convenient.

2.1. Search Strategies for Literature Review

The search strategy focused on finding relevant information about the nursing profession in Kuwait, Qatar, Egypt, and Jordan. Therefore, in this chapter, the search for the literature has been performed by using a variety of search tools, such as online databases, books, journals, academic papers, and articles. A comprehensive search for academic and non-academic literature has been conducted through NTU Library OneSearch, Ethos library, Cochrane Library, SCOPUS databases, EBSCO / CINAHL Database, Google Scholar, and Google search engine. This search was developed to achieve the research aim and objectives, hence an intensive search for the literature related to the profession, professionalisation, and professional development. While searching for the literature several terms and concepts associated with the profession have emerged such as training, knowledge, resistance, and path dependency. Then the search criteria were divided into inclusion criteria (literature related to profession, professionalisation, professional development, the nursing profession, nurses, wound management, skin integrity, TVNs). The inclusion criteria focused on the literature that is relevant to the nursing profession background, alongside the nursing profession development in Kuwait, Qatar, Egypt, and Jordan. On the other hand, the exclusion criteria (literature that does not consider the previous terms and concepts). Therefore, the research scope was broad at the beginning and the evolutionary process while conducting the research, resulted in narrowing the scope of the research hence making it focused. The search considered health workforce planning, health policy, regulations, and recruiting. Besides, while searching for nursing development, new concepts have emerged such as gender inequality, patriarchal culture, and institutional inertia. Some of the concepts were new, thus allowing the development of keywords that are relevant to the concept as shown in Figure 2.1.

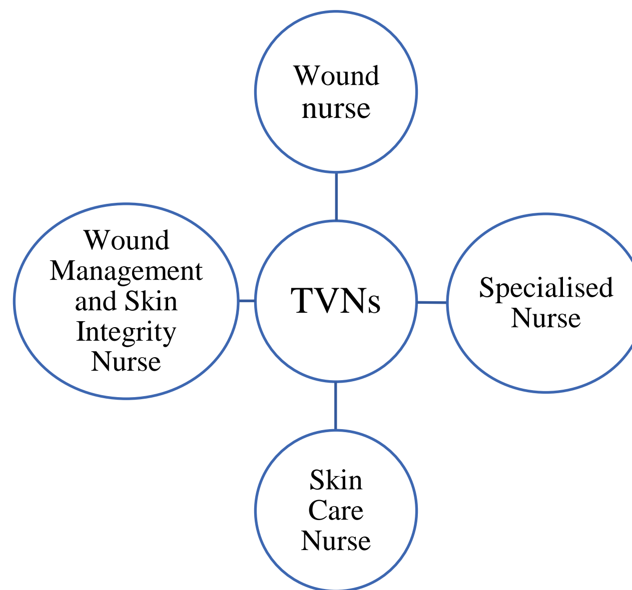


Figure 2.1: Search Keywords

A preliminary search was conducted to have an idea of what research has been done about the same topic and to identify the appropriate sources to find the relevant information. Consequently, the data was concise between 2005 to 2023, however, some literature was not available within this timeframe in Kuwait, Qatar, Jordan, and Egypt. Therefore, in this case, the available resources were used as a reference even if it is outside this time frame. These data sources were evaluated according to their relevance to the research topic and question and then the quality of information was reviewed and analysed for the source's authority, accuracy, and reliability (Lau and Kuziemsky, 2016). Hence, the literature reliability is ensured by considering inclusion and exclusion criteria as mentioned in the last paragraph. It is also necessary to avoid bias in research because it can affect the accuracy of research by modifying the results in a particular direction, which could lead to inaccurate conclusions. Further, it can undermine the validity of the study and hence might have serious implications if the study results are used by the decision-maker, for example, affecting public policy negatively. Therefore, the information was discussed with the supervisors to develop the knowledge and to understand the topic in depth, further, to make sure it supports the research questions.

2.2. Profession, Professionalisation and Professionalism

Professionalisation is a social process that is related to the profession (Leigh, 2017; Yagatich, 2018). It involves a mix of social behaviour such as interacting with others, influencing society, and getting shaped according to society. It also refers to individuals'

attitudes, behaviours, and commitment to moral and ethical behaviour (Lehmann et al., 2018). Since professionalisation is a social process, it would be useful to apply it in social science studies to provide different sociological perspectives and an in-depth understanding of the issue related to the lack of nursing specialities particularly TVNs, under the lens of professionalisation. D'amour et al. (2005), Reeves et al. (2013) and Snowdon, Leggat and Taylor (2017) stated that the sociology of the profession reshapes and enhances healthcare services, by examining the social structures and dynamics of the profession which helps to understand individuals' behaviours and interactions within the profession. For example, the healthcare structure is designed based on the healthcare system's professional roles and power dynamics which helps to differentiate between healthcare professionals such as nurses or doctors; to promote patient care and coordinate services according to their professional roles. In order to understand service delivery and professional role distribution, Wall and Hallett (2018) highlighted that the professionalisation of nurses enhances the understanding of the development of nursing as a career. For example, professionalisation helps nurses to establish a distinct professional identity which is developed according to their knowledge and skills. This professional identity articulates nurses' roles and responsibilities according to the nature of the nursing career. Further, the professional knowledge and skills of nursing are established as standards that guide nurses in decision-making. However, Miller and Rose (1990), Fournier (1999) and Maristany et al. (2023) considered professionalism as a force of control. For example, professionalism can be used to control the employee in some ways through guidelines and policies which could encompass challenges.

Brunner and Kada (2010), Ghadirian, Salsali and Cheraghi (2014) and Kolsaker (2014) described the profession and professionalism as a dynamic process that requires updating knowledge. It involves ongoing learning and development, further, following the established professional standards (Evans, 2008). Therefore, professionalism strengthens the individual's roles in the organisation, by providing the freedom to control their work, which helps to empower the individuals in decision-making. Quicke (2000) highlighted that profession and professionalism play an integral part in understanding modern societies. For example, individuals need to be aware of technology and update their knowledge. Further, it is commonly used in the context of qualification, training, and continuing development (Mulder, 2014). This entails that developing the profession requires a high level of knowledge and training, thus, expected to be appropriately organised and managed in a systematic way to come out with best practices. Also, individuals are required to update their knowledge which is an

ongoing process, further individuals need to adapt to the changes. Therefore, introducing a new nursing speciality could not be welcomed and failure to adapt to the healthcare changes might lead to challenges, these challenges are exhibited in Figure 2.2.

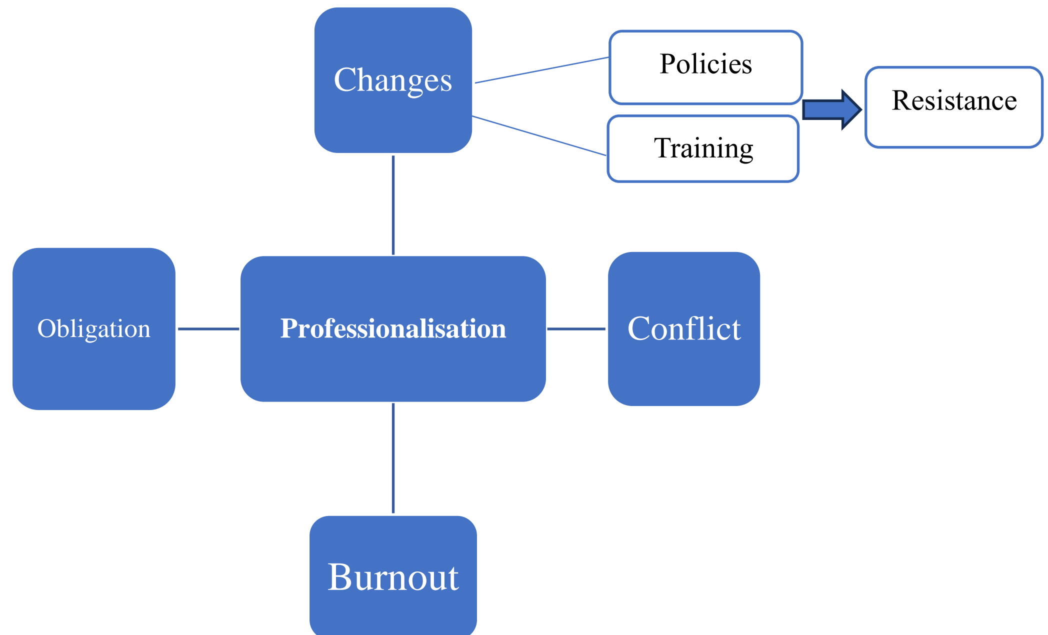


Figure 2.2: Challenges of Professionalisation

2.2.1. Challenges Associated with Professionalisation

2.2.1.1 Conflict and Burnout

Lowther and McMillan (2006) stated that professionalisation includes social behaviour, activity, or interaction such as conflict, competition, and cooperation. Professionalisation assists in decision-making under tough circumstances, hence it enhances the ability to manage conflict effectively (Leigh, 2017; Yagatich, 2018). Despite that, Leiter (1991) argued that professional and professional duties lead individuals to conflict or burnout due to the consistencies in their professional roles. Conflict is a disagreement or clash between two or more parties, often related to differences in goals, values, or opinions (Boutron et al., 2019). In the workplace, conflict can be caused by a range of factors, including communication breakdowns, power imbalances, domination, and competing priorities. Professionalisation could lead to conflicts in various ways, for example setting priorities and goals according to the interest of the profession. Also, conflict might exist between doctors and nurses related to their professional roles and levels in the organisation's hierarchy. On the other hand, burnout is a state of physical, emotional, and mental exhaustion caused by overwork leading to

prolonged and excessive stress, which can result in a decreased sense of accomplishment and feelings of detachment and cynicism toward work (Maslach and Leiter, 2016). It is a common phenomenon in healthcare settings, including nursing and medical professions (Dall'Ora et al., 2020). Burnout also develops from an unrealistic expectation of the profession such as expecting to be excited all the time or receiving appreciation from patients. Thereby, it can lead to decreased job satisfaction, increased turnover rates, as a result, a decrease in the quality of care. To avoid these things, effective policies are required related to professional roles to avoid conflict and burnout. Further, authorities need to be clear so individuals will not have high expectations, such: as reducing workload or more allowance.

2.2.1.2. Resistance

The previous chapter shows that Kuwait, Qatar, Jordan, and Egypt are investing in different quality programmes in order to improve health services. Also, Kuwait and Qatar are investing significantly to improve their healthcare facilities and systems (Chapter One, Section: 1.8, pages: 30-31). According to Kamal, Abdulwahab and Al-Zaid (2021) and Statista (2023c), Kuwait's and Qatar's healthcare systems are under continuous progress and in a constant influx of healthcare professionals. Ginter, Duncan and Swayne (2018) highlighted that persistent healthcare change is considered to be an opportunity that enhances the development of new services. For example, there is a necessity to build a new nursing speciality in tissue viability, to deal with complicated wounds and enhance skin integrity. Despite that, the change could be considered a burden if people do not accept it. Infact, individuals tend to resist any change in the system or the flow of the system, because they get exhausted and then burnout due to the continuous learning process. Different researchers believed that fear and anxiety about change could result in resistance (Ford, Ford and McNamara, 2002; Pieterse, Caniëls and Homan, 2012). Developing a new speciality could be associated with stress and fear which could create resistance to accepting new changes in their practice. Knowledge deficiency can lead to resistance due to insufficient training or a lack of updated policy. Also, the allied health profession might resist developing the new speciality due to conflict of interest. Based on Field and Lo (2009: 46), a conflict of interest is:

"*a set of circumstances that creates a risk that professional judgement or actions regarding a primary interest will be unduly influenced by a secondary interest".*

Therefore, the stakeholders must expect resistance from the nurses or the allied health professional, while developing a new speciality. To avoid such things, managers and leaders

must develop a culture of change within the organisation, which can be developed easily from their knowledge and skills about the current change. Effective leadership can assist the organisation in delivering safe and best health services, thus, will have an essential impact on the organisational services and will develop a culture of change in the organisation (Nelsey and Brownie, 2012). Developing a culture of change could assist the nurses in accepting the new speciality with less resistance. Therefore, developing a new speciality would need leaders' support, to consider these issues in order to develop TVNs. This shows that developing TVNs requires the existence of effective leadership to manage staff resistance in Kuwait, Qatar, Jordan, and Egypt.

2.3. Toward Professionalisation

In order to develop specialised wound nurses, there are several aspects that need to be considered, some of these aspects are given in Figure 2.3 below. This part analyses all of these aspects.

Figure 2.3: Steps to Achieve Nursing Professionalisation

2.3.1. Training and Profession

Saarikoski and Toivonen (2015) described professionalisation as an effective transformation of the healthcare staff that leads to improving the health system by enhancing the quality of the care provided through successful mentorship. This in general, aims to improve the lifelong learning needs of the nurses by developing a consistent training programme in order to transfer this knowledge to other nurses (*ibid*). In return, those nurses will pass their knowledge to other nurses and health professionals which would improve the human capital (Riklikienė and Tichelaar, 2018; Clinton et al., 2018). However, individuals might continue their previous practice even after training, which refers to path dependency. When the decisions and events that occurred in the past impact the current situation and limit the available options for future development, this is described as path dependency (Barnes, Gartland and Stack, 2004; Kay, 2005). In healthcare organisations, path dependency can occur when certain practices or processes become entrenched, and it becomes difficult to change them even if there are better alternatives available. Therefore, a study performed by Jin and McDonald (2017) stated that the key factor for effective services is training combined with

staff commitment. Hence, evolving TVNs require appropriate training for nurses to come up with the expected output. On the contrary, providing training without staff commitment would waste efforts and resources. Communication also must be addressed to ensure all the employees are benefiting from this training. Nørgaard et al. (2012) emphasised that communication and training have a vital role in developing employees professionally. Effective communication also could be used to ensure relevant training is available related to the change of individual practice and role (Klein, 1996). Hence, developing a new nursing speciality would be more beneficial for the organisation, through transferring the knowledge from a small group to a larger group.

Both training and policy are important to increase nurses' awareness of the TVNs and further provide direction for nurses to comply with any changes in their practice (Mathieson, Grande and Luker, 2019). Nevertheless, nurses' lack of awareness of the current policies and guidelines is pertaining to a lack of training (AbuAlRub and Foudeh, 2017; Turale and Kunaviktikul, 2019). Kinnie et al. (2005) and Brynard (2009) stated that commitment is the main factor for the successful implementation of the policy, and the main drive for employee commitment to the policy implementation is training. So, training and commitment are relatively significant to the successful development of TVNs. Moreover, the World Health Organisation (2006b) determined that knowledge and training are significantly supporting policy and decisions. Thereby, the policy must be associated with actions to perform decisions, this relationship is exhibited in Figure 2.4. In addition, providing effective training and updated nurses' knowledge related to services could elevate nursing social status in society. However, there is a lack of focus on nursing training in Kuwait. The World Health Organisation (2015) stated that Kuwait needs to spend more effort in assessing human resources and providing adequate training for all healthcare workers, especially nurses. This lack of nursing training could be an indication that the M.O.H./ Kuwait is not considering nursing as an integral part of the healthcare system. The lack of training can also be an underlying factor related to nurses' resistance in Kuwait along with their lack of professional development.

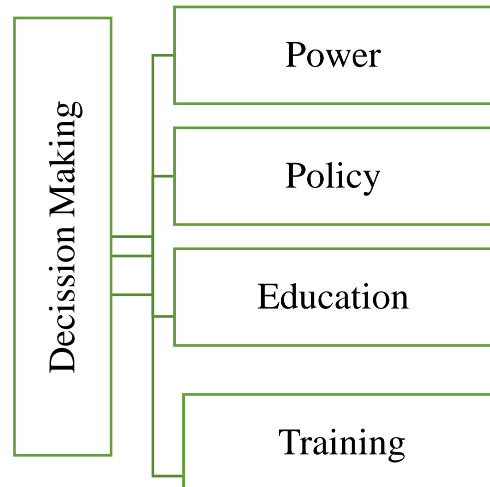


Figure 2.4: Factors Associated with Decision Making

2.3.2. Values, Norms, Knowledge, and Skills

Developing TVNs requires specific knowledge and skills, which shape the values and norms of the profession, in order to enhance individuals' ability to practise independently. Yagatich (2018) emphasised that professionalisation supports applying certain knowledge in the real world. Professionalisation refers to the process of making the profession more recognised through owning specific knowledge and skills; further, makes the profession more systematic with defined roles, standards and education (Légaré et al., 2011). Some knowledge could be owned only by certain professionals such as the knowledge of skin and tissue are linked to TVNs. This knowledge allows nurses to work independently or collaboratively with other health professionals. According to Bezes et al. (2013), professionalism focuses on the individual's performance and competition, due to their substantial role in the organisation's success or failure. Therefore, professionalism enhances the efficiency of individuals by introducing new occupational values that take place in organisational management. Also, O'Sullivan (2012) and Trede, Macklin, and Bridges (2012) stressed that the main step in understanding the theory of profession and professionalism is to define its values. If individuals are following the same code of ethics in a specific profession; those ethics influence and shape their values and beliefs based on certain behaviour. These behaviours and values are considered as boundaries for the profession, so individuals cannot exceed them. For example, nurses who are exposed to patients' bodies or skin diseases are expected to protect patient's privacy and confidentiality, by avoiding sharing patients' matters with other colleagues. Furthermore, professions are often associated with ethical dilemmas, due to the ethical and moral responsibilities of their professional role. Sometimes nurses face critical situations that

challenge their ethical behaviour and moral principles, for example, nurses cannot use their judgement to end patients' life, in order to relieve patient's pain. In regard to wound management, Samuriwo et al. (2020), argued that making an appropriate decision is the most challenging process for healthcare professionals, especially in skin care and wound management. Decision-making related to wound management is a complex process that requires considering different aspects (Chapter One, Section:1.3, page: 8) and must be developed according to the knowledge and evidence while considering the ethical and moral principles of the profession.

2.3.3. Professional State and Identity

Nyström (2009) determined that the development of professional identity can restructure the knowledge and experience to perform the best practice. Besides, Willetts and Clarke (2014) highlighted that there is no existence of any profession without a professional identity, and this includes values and policies to help in the decision-making process. It has been suggested that the profession can strengthen the individual's characteristics by building positive behaviour based on their knowledge and unique skills, so their role within the society will be expanded, this will give them prestige and then increase their social preference (Saks and Burke, 2012). The professionalisation could lead to increased recognition and respect for the nursing profession. This is based on social legitimacy associated with known professions. When only TVNs are familiar with new approaches to improve skin integrity or wound management, this could increase the community's trust in nurses. Gregory and Austin (2019) stated that a strong professional identity is a symbol of a healthy professional state and that identity rose significantly in health professional education by supporting health practices. Hence, individuals select their careers based on their personal interests or professional prestige (Mehmood et al., 2012), such as surgeons or scientists (Eremie, 2014). These types of professions have a high professional identity due to the amount spent on education and training that used to own wider knowledge. Therefore, these professions are more dominant, and individuals might feel superior to others. On the contrary, in the case of Kuwait, there is a lack of investment in the nursing profession as in terms of higher education, the education system in the country does not provide facilities for nursing postgraduate studies, unlike Qatar, Jordan and Egypt (more details will be provided later in the chapter). The lack of complete educational facilities for nursing in Kuwait could indicate the lack of professional identity for nurses in the country. Further, there is a lack of training as mentioned in (Section 2.3.1, page: 40). This led

to the low social standing of the nursing profession, and then a weak professional identity. Weak professional identity and state mean there is a lack of community interest in the profession, because of insufficient training and failure to acquire specific knowledge related to the profession (Pratt, Rockmann and Kaufmann, 2006). Therefore, enhancing the professional state involves the development of self-regulation and self-awareness which gives the opportunities to grow professionally. Although, these advantages are associated with self-sacrifice, responsibilities, and limitations to moral and ethical behavioural standards. Henceforth, this limitation might be considered as a restriction for some, then ends in anxiety (Traulsen and Bissel, 2004; Aukett, 2017). Some individuals who are not keen to commit to their job responsibilities will look into professional norms and moral principles as an obstacle. Further, there are various aspects that affect nurses' identity and their social status as explained next.

2.3.3.1 Gender and Profession

Gender plays a fundamental role in evolving professional status and choosing a career. Some careers and professions are considered for males or females based on social perception. For example, pilots are usually males and secretaries are females (Andreevna, 2020). Over the years, women have faced bias and discrimination, for example, some societies and norms consider men superior to women and this is reflected in the wage gap. This in return, affected the working status of the female. So far, females are underrepresented in some professions such as engineering or mathematics (*ibid*). The role and the position of females have dramatically changed over the years, especially in the 19th and 20th centuries when females started to work in the industry. This helped to change the common concept about female roles in society such as nursing needy individuals (Prochaska, 1980). However, Wingfield (2009) stated that females now can be seen in several professions such as science or engineering. In this regard, Monk (2011) asserted that the feminist movement is now well-established in many disciplines, for example, engineering, physics, and sports.

Generally speaking, in the Gulf region females were used to be neglected and considered inferior to males and had lower status than them, in terms of restricting their political and civil rights such as voting or participating in the parliament (Tétreault and Al-Mughni, 1995). In this context, in 1999 Kuwaiti Emir Jabir Al-Ahmed permitted females to get their political rights in the country. However, the Kuwaiti parliament rejected the proposal twice in the same year. Nine years later, the proposal got approval from the Kuwaiti parliament.

The state of Kuwait is always trying to maintain impartiality between both genders, by supporting male and female education and giving the chances for both genders in leadership positions. However, the government cannot make any bold decision without approval from the Kuwaiti parliament. For instance, any proposal that is suggested by the government requires approval from more than half of the parliament members. Unfortunately, some political parties do not support female equality along with their increased role in social activities and some claim it is against the role and regulations of Islam (Tétreault, 2001; Al-Sabah, 2013). In addition, Tétreault and Al-Mughni (1995) argued that some political parties consider females as a threat to their political positions. Despite that, Kuwait experienced a transition role of female (Al Sabah et al., 2019). For example, the number of female doctors who are holding leadership positions in Kuwait has dramatically changed between 2006 to 2018 as shown in Figure: 2.5 (it shows the increasing role of female doctors from 2008 to 2018, during the same duration the male representation in the profession is decreasing). Hence, the female chances to lead the departments became equal to males (*ibid*). Inspite of that, Nombela (2014) and Burnett and Lloyd (2020) asserted within values and norms there can be a hidden aspect of domination. For example, males are dominant in Kuwait and the policy is designed in a way to support them. On the other hand, it does not support Kuwaiti females in some respects. For example, the lack of effective policies affects even Kuwaiti females to have equal rights similar to Kuwaiti men. Tétreault (2001) and Drennan and Ross (2019) stressed that there is a pay gap between Kuwaiti females and males, although they are performing similar duties and responsibilities. The Kuwaiti government considers men more responsible and have various duties to care for such as their families whereas females are considered to have fewer responsibilities. This makes them eligible to have more salary which reflects gender inequalities along with patriarchal culture as will be explained next. Further, the Kuwaiti female has no right to transfer her Kuwaiti nationality to her children or husband from different countries, despite that, the system is supporting Kuwaiti males in that regard (Equality Now, 2021). In addition, a mother cannot decide on behalf of the husband regarding their children's health procedures or school admission. With these challenges and biases, females in Kuwait cannot make decisions. Therefore, in a profession such as nursing which is mainly occupied by females, it would be difficult to allow them to make decisions regarding skin integrity and wound management.

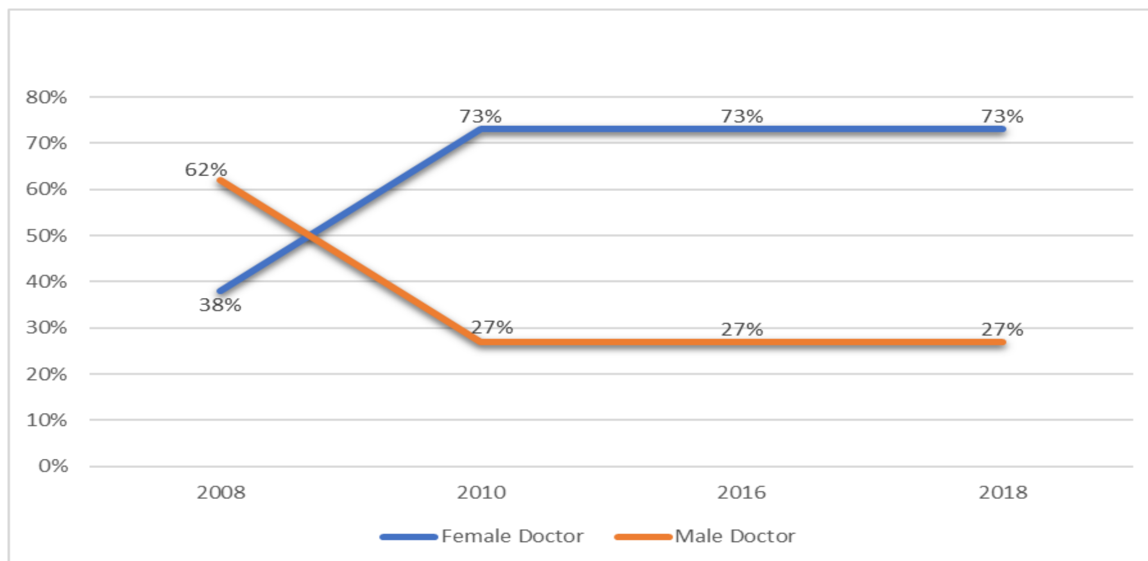


Figure 2.5: Female and Male Doctors in Leadership Positions Adopted from Al Sabah et al. (2019)

2.3.3.2 Gender and Culture

The female role in society is adversely impacted by cultural perspectives and perceptions. In relation to the profession, the previous section shows that in a conservative society, female roles are limited due to the gender inequalities that developed from the culture of Arab society. This culture influences the role of the female inside and outside the home (work), where usually the leaders are males. Further, males are the ones developing the policy in their favour, for example, restricting females from performing their political rights (see section 2.3.3.1), because of that culture where men consider females less than them physically and mentally (Euro-Med Human Rights Monitor, 2019). Besides, when it comes to a female profession such as nursing there is a lack of supportive policies and regulations that make nurses' status very low in Kuwait, this also leads to increasing nurse turnover in the country (WM, 2019). For example, the immigration policies in Kuwait support neither married females nor single females. Lack of support from the immigration policy in Kuwait for female workers leads female nurses to find alternative working opportunities in foreign countries. Indeed, female nurses have more restrictions such as: not being allowed to leave the nursing hostel for certain hours. The issue in the Middle East related to females is not restricted to the nursing profession alone, instead females in general are subject to limitations and these have existed since ancient times, due to female roles in society such: as wife, mother, or sister (Tumulty, 2001). Therefore, culture and gender significantly influence the profession as well as the role of the female in the profession. For instance, the nursing profession is considered a female

profession, hence, the female role in this profession is limited to following doctors' instructions and performing basic nursing tasks such as checking vital signs (Al-Kandari and Ogundeyin, 1998). These issues are rooted within society due to the patriarchal culture and generate gender inequalities and male domination, which require addressing by the stakeholders and enhancing the female role in society.

2.3.4. Policies, Regulations, Administration, and Institutional Inertia

2.3.4.1 Health Policies and Regulations

With population growth and increasing healthcare demands, the perspective of profession and professionalism have been expanded, hence, the necessity arose to develop a new policy to meet the expectations of the profession, community, organisation as well as individual needs. Sometimes institutions find it difficult to innovate because they like to follow the ways of previous practice, which is known as ‘path dependence’ (Section: 2.3.1, page: 40). Therefore, it is essential to understand the relationship between health policies, institutional behaviour, and political power, in order to advocate the new nursing speciality in Kuwait, Qatar, Jordan and Egypt. Health policy is identified as a national and international health goal that requires plans and actions to achieve that goal (World Health Organisation, 2006a). It plays a significant role in reforming the current position of nurses and midwives (World Health Organisation, 2006b; AbuAlRub and Foudeh, 2017). As well as driving professional standards and influencing towards improving the competency of individuals in a certain field (Evans, 2008). It is also known as a legacy that influences the undertaken decisions by private and public agencies (Ham, 2009). This shows that policy could have the power to influence an individual’s practice. Therefore, the power of health policy could have positive or negative impacts, depending on how effective it is in improving patient care and changing nurse’s practice. Mason et al. (2007) stated that the main aspect of evolving health policy is to make effective decisions in order to support the public well-being. However, Steelman and Ascher (1997) argued that not necessary policy will lead to the best decisions, especially when the policy is developed based on public interest without planning, which could create a dispute. This is also known as a conflict of interest (Section: 2.2.1.2, page: 39). For example, developing policies based on personal interest and benefits, like commission from a company.

The development of policy assists in establishing a strong structure for a particular field, by producing the relevant instructions and regulations for the organisation. Hence, the policy could be used effectively to support the development of TVNs if individuals adhere to it. In this context, Alias (2019) and Khatib and Barki (2022) argued that individuals' attitudes toward policies are influenced by compliance benefits and non-compliance costs. For example, promotions or rewards would motivate employees to comply with the policy. In contrast, employees could be motivated to comply with the policy if there is a cost for non-compliance like a penalty or other consequences. Further, Argyris and Schon (1992) and Argyris (1995) argued that the policy is written but it does not mean it is used in practice. Hence, it is important to understand more about the organisational culture because if the policy does not align with the culture, it might be rejected by individuals. For example, the policy could support nurses in making decisions related to wound management, which could be unacceptable to doctors, due to issues of power and control, or due to domination issues and gender inequalities (Sections: 2.3.3, page: 42; Section: 2.3.3.1, pages: 43-44).

The governments in Kuwait, Qatar, Jordan, and Egypt set a strategic plan to develop health services, by updating or changing the current policy according to the needs. However, some issues interfere with the development of new policies, due to political preferences or power influences. Thereby, a new policy must develop or update the existing one to give accurate information and guidance about TVNs in the respective countries. Based on Leiter (1991), Freidson (1999), Jacob and Boisvert (2010), and Oberhuemer (2015), professionalisation is a set of regulations, standards and policies that could support the professional development of the employee in a certain discipline, further, it constructs the daily activity and routine to develop an independent professional practice. Also, Doyle et al. (2016) stated that policy-driven professional standards and influence improve the competency of individuals in certain areas. This implies that profession and policy are both interlinked to develop the nursing profession and initiate a new speciality. However, when policy lacks support this can adversely affect the development of health services and then it would be difficult to introduce a new health profession (Barry and Chapman, 2009). For instance, if the policies do not support training programmes, this could inhibit the development of TVNs. In addition, Steenbakkers et al. (2012) emphasised that flexibility in the work along with changing the policy according to the needs could enhance the outcomes. As an example, distributing clients among morning and evening clinics in the outpatient department could reduce the workload for nurses and other health professionals. This would enhance staff satisfaction with

the policy or regulations, therefore, increasing their productivity and decreasing work overload. However, some changes could be ineffective and might increase staff workload. Besides, initiating a policy for a new nursing speciality is considered to be challenging, because it requires expert opinion, training for the policy and financial support (Oberhuemer, 2015). Likewise, Frenk et al. (2010) highlighted that the development of health services needs investing in nurses' skills to overcome the associated challenges with developing a new nursing speciality. This indicates that nurses must have the skills and knowledge to improve health services, and this could be achieved by updating the policies and guidelines. Therefore, developing TVNs requires sufficient resources to support the implementation of the policy regarding this speciality.

2.3.4.2 Administration, Institutional Inertia, and Nepotism

When administrative and organisational obstacles impede the delivery of quality services this is known as bureaucratic issues (Dussuet and Ledoux, 2019). For instance, organisations might have rigid policies and procedures that do not allow for flexibility, which can create unnecessary obstacles and hinder nurses' productivity, such as using both manual and electronic documentation to record patients' notes, where one documentation type is enough. On the other hand, nepotism, or the concept of "Wasta" is identified as personal or social connections that give the power to achieve a specific aim, which is commonly applied in Middle Eastern countries (Al-Enzi, 2017). Individuals who have "Wasta" can work in special hospitals with more allowances and benefits without considering their experiences or skills. On the other hand, qualified individuals will be working in clinics where there is a lack of promotions and low wages for employees. Wasta helps incapable individuals who have no qualifications or irrelevant qualifications to be in a powerful position. This could adversely affect health services. For example, individuals with less experience and knowledge could lack direction and understanding of the work circumstances and then make poor decisions. Wasta is a bureaucratic issue that is deeply rooted in Kuwait (*ibid*), it is difficult to obtain the most basic rights if one does not have the required connections or relevant Wasta. Wasta is more dominant than qualifications and competencies in Arab countries (Tlaiss, 2013). As an example, if individuals have relatives or friends in the parliament, it is quite common to take full advantage by working in the best departments in the country with more salaries and further allowances. Wasta does not necessarily mean that someone is working in the parliament. However, it certainly enables incapable individuals to occupy influential positions in the public and private sectors. The most common practice of Wasta is when people working in a

management position, where they can give favour to other relatives or friends without considering their capabilities or qualifications.

Consequently, this has affected the nursing profession in Kuwait, where nurses with emergency or Intensive Care Unit experience are being assigned to the surgical or medical wards and vice versa. According to Mason et al. (2020), nursing practices are highly influenced by government policy. For example, the school nurses programme stopped for more than 15 years in Kuwait and then the government proposed a new policy to allow nurses to work again in school. The home visit where nurses provide care for critical patients has been stopped for a few years. After several complaints from patients, the government introduced a new policy that allows doctors and nurses to provide home visits for critical patients. Hammond and McLaughlin (1995), Steelman and Ascher (1997) and Timmermans and Oh (2010) stated that emerging new health policies help to transform the social perception of the profession. This also endorses the positive relationship between policy and professional development. Eventually, if society has a positive thought of the profession this would boost trust in the profession, then support professional development and facilitate the establishment of TVNs. This illustrates that the policy should be flexible to support the profession and give direction to nurses otherwise it will mislead them, resulting in poor decisions and then leading to a lack of respect and mistrust of the society. Policies and regulations are part of professionalisation development; hence, the decision-making process will be limited to policies and regulations only, which decreases the effectiveness of the decision if anything beyond those policies. However, some institutions resist any changes by stabilising their policies, which is known as, institutional inertia (Rosenschöld, Rozema and Frye-Levine, 2014; Angeles, Ngo and Greig, 2021). For example, if policy is not effectively practised in some health organisations, this might hurdle the development of TVNs. The institutional inertia results from rigid organisational behaviour and culture leading to resisting any change by stabilising the current policies. Therefore, considering developing the policies might not be effective in this type of organisation.

2.3.5. Profession and Power

The intention of evolving specialised nurses related to skin and wounds is to enhance the nurse's role in the organisation by giving them the ability to decide effectively based on their knowledge and skills, which gives nurses the power to operate effectively and play a prominent part in decision-making. This power is associated directly with an individual's

beliefs, knowledge, and behaviours (Erooga, Kaufman and Zatkin, 2020). It also influences the behaviour of persuasion, coercion, and suggestion. Macheridis and Paulsson (2019) stated that the profession gives a power that highly supports the employees in their performance. This power could be in several ways such as giving the authority for decision-making or practising the norms and values. Dahl in his 'Concept of Power' (1957) as an action that is held by a powerful individual to control and make limitations for others. For example, using the power to make decisions and allocate resources. Sometimes this power is used to colonise or decolonise knowledge by the people with more influence and control in the system. Colonising knowledge refers to the practice of appropriating knowledge from marginalised communities and cultures without giving proper credit or recognition and often using that knowledge for personal gain or to reinforce existing power structures (Bhambra, 2007; Núñez-Pardo, 2020). Likewise, Bhatti-Sinclair (2022) defined colonising knowledge as the exclusion of certain knowledge and practices in the favour of dominant parties such as doctors. For example, nurses might conduct research to develop new knowledge related to dealing with chronic wounds, but the credentials will be for doctors only. This could be an indication that powerful individuals usually control the knowledge in their favour. In contrast, Büyüm et al. (2020) describe decolonising knowledge as active resistance to colonising knowledge, such as deskilling nursing professional knowledge and preventing nurses from attending training or conferences.

The differentiation between specialisation and professionalisation would help to understand the power. Azu and Naidu (2013) stated that the orientation toward specialisation has increased noticeably in recent years. Whereas professionalisation can lead to specialisation, for example, the development of specialised areas of healthcare services, such as the speciality of tissue viability. Bourgault and Parent (2008) and Pace et al. (2010) emphasised that the profession developed from the following characteristics: the body of knowledge and skills related to a specific area, which aligns with specific norms and principles that guide employees in their work. Therefore, professionalisation is broader than specialisation as it enables individuals to have the knowledge, standards, characteristics, skills, and values (White, 2000). This knowledge must be owned and generated by nurses themselves. For example, TVNs have special knowledge related to skin conditions and the wound-healing process, this knowledge gives them the power to participate in the treatment plan. Therefore, professionalisation increases the expertise and knowledge of nurses through developing specialised areas of healthcare. This entails that having specific knowledge or skills in the area of speciality would assist in cementing the profession and then enhancing nurses' power. This power is essential

for any profession when it comes to self-satisfaction, decision-making, and changing organisational setup. Profession and power are essential to enable individuals to make decisions based on their knowledge and skills, further, this would mitigate the conflict resulting from role misconceptions. For example, sometimes, physicians ask nurses to do their tasks such as writing in the request form for different procedures. Having the power would eliminate the chances of conflict with other health personnel. Knowledge could boost nurses' role regarding wound management and skin care; however, it is not necessary that knowledge would give them power. Based on, Hampton et al. (2009) and Pac et al. (2010) professions vary in terms of authority, power, and decision-making. For example, nurses could have the knowledge and skills that could enhance their power, yet in decision-making, they require authority.

In the working environment, there are different types of power, this power is organised according to different levels in the health system hierarchy. It could be visible through the hierarchical level within the organisation, invisible and hidden power (Gaventa, 2006; McKee, Steele and Stuckler, 2019). The three powers in the hierarchical system are given in Table 2.1 Understanding the power dynamics in the organisation could help to advocate for new nursing specialities in Kuwait, Qatar, Jordan, and Egypt.

Table 2.1: Different Powers in the Hierarchical System

Hidden Power	Visible Power	Invisible Power
It is a power held by informal individuals who influence and control the people who are making the decisions (VeneKlasen and Miller, 2002). This power dynamic is commonly utilised in different organisations, to shape new political agendas based on individual demands and increase the legitimacy of their issues.	This type of power is controlled by official individuals who have the authority to develop the structures, strategies, and rules for decision-making (VeneKlasen and Miller, 2002). This type of power is more democratic and accountable and is used to reform the policies according to society's needs.	This power shapes the way an individual thinks and understands what is acceptable or not (VeneKlasen and Miller, 2002). It shapes the ideology of individuals and develops the meaning. Therefore, individual beliefs, behaviour, and acceptance of the status quo (like superiority or inferiority). This power aims to change individual consciousness to change the social and political culture.

Adapted by Just Associates from VeneKlasen and Miller (2002)

2.3.5.1 Professional Hierarchies and Power

Based on McKee, Steele and Stuckler (2019), if an individual gives up some power, others will obtain that power. For example, in the case of decision-making, doctors have the power to make decisions related to wound management. Hence, to gain that power of decision making the doctors should give up, which could end with conflict and challenges for nurses due to the doctor's powerful position within the organisational hierarchy. According to Bartos et al. (2008), there is a significant relationship between power and leadership and the following is presented in Figure 2.6. Professional hierarchies are influenced by cultural, educational, and legal pressures, which make nurses obedient to doctor orders without questioning (Fernandes and Ecret, 2019). Nurses' subordination is not only an organisational or practical issue but also a theoretical and academic issue. In educational terms, nursing students are taught to follow the orders of doctors such as in (*Handbook for Brunner and Suddarth's Textbook of Medical-surgical Nursing. Wolters Kluwer Health,* 2010, P:525). Based on a study conducted by Reis, Wald, and Weindling (2019: 3) escribed Medicine as

"a hierarchical profession, with senior clinicians issuing orders to be carried out by junior ones, and where physicians often direct or command allied health personnel. While these features of medicine are applied with the noble goal of healing and administering best practices within humanistic care, the combination of elements of hierarchy, obedience and power constitutes a risk factor for abuse of power".

Figure 2.6: Power in the Health Organisation (Bartos et al., 2008)

Therefore, the hierarchical nature of medicine as a profession is embedded in both clinical education and practice, which reflects a hierarchical power imbalance between doctors and nurses. Also, O'Shea, Boaz and Chambers (2019) highlighted that the power dynamic and variations in power status are widely documented in healthcare structures. This results in different issues such as domination and obedience. Doctors as professionals use their power to

influence and shape the healthcare system, as well as distribute the professional role according to their benefits. For example, the policymakers in the M.O.H. in Kuwait are doctors by profession, further in the health organisation hospital directors are always doctors, therefore, the fear of facing some consequences due to doctors' power, would naturally influence nurses to obey doctors' instructions without questioning. This could be referred to the organisational behaviour and culture.

2.3.5.1.1. Organisational Behaviour

Employees' actions and practices in the organisation are described as organisational behaviour (Hoogervorst, van der Flier and Koopman, 2004). This behaviour is mainly developed to help the organisation achieve its goal. It is important in sociology to focus on understanding how individuals and groups interact in organisations, how organisations function as a whole, and how to manage people and groups to improve organisational performance. This includes understanding the organisational culture, values, beliefs, and norms that shape an organisation and how they could impact employee behaviour. Besides, understanding how to build effective teams, and how to manage conflict in the organisation by understanding the group dynamic and how individuals interact within the health organisation. As a result, the manager would be able to deal with individuals' behaviour effectively and minimise individuals' resistance. Aswathappa and Reddy (2009), stated that organisational behaviour includes employees' knowledge, skills, capabilities, intellectual skills and much more. Therefore, individual behaviour varies from one to another, which makes it challenging to deal with all employees similarly. Hence, some individuals might adopt silence in the interviews which could reflect something deeper. Sacks (1992: 101) identified silence as:

"*An accountable mode of communicative action*".

Tutar, Tuzcuoğlu and Sarkhanov (2021) described silence as a form of non-verbal communication that conveys various meanings. Therefore, it is important to understand the factors leading to organisational silence, in order to develop TVNs in Kuwait, Qatar, Jordan and Egypt. This could indicate agreement or disagreement, depending on the way that is delivered and interacted. This silence is studied and constructive, further, it is considered as an intelligent action, that individual attempts to avoid threats or demands (Lynch, 1999). From a socioecological lens, silence can be as important as what is discussed, and it is a prevailing tool for preserving or challenging dominant social norms and beliefs (Jung, 2019). In the organisation, silence, and avoidance of expressing feelings or sharing reality could be seen

frequently. According to Van Manen (2006: 719), "*Language may kill whatever it touches*", and qualitative researchers understand that it is impossible to truly "*say something*". The qualitative research focuses on understanding what is behind the silence and why individuals prefer silence rather than talking as this could be a result of fear or organisational culture. Morrison and Milliken (2000) defined organisational silence as a situation where individuals in the organisation consciously avoid talking or expressing their thoughts and concerns about the organisation's internal issues. Silence could have a negative impact on organisational development and progress, decision-making, organisational capacity, and ability to change (Labrague and Santos, 2020; Creese et al., 2021). Organisational silence can be also a form of defensive behaviour, where individuals are cautious in sharing information, to avoid conflict with the administration. (Further details about the organisation's defensive behaviour is provided next).

2.3.5.1.2. Organisational Culture

Organisational culture can impact inter-departmental relationships for example, departments with people from different cultures might struggle to work together effectively, leading to conflicts and reduced collaboration. Organisations need to develop a shared culture and values that are aligned with the overall goals of the organisation. Organisational behaviour might be similar to organisational culture, so by understanding the culture it is possible to figure out how to deal with employees' behaviour (Huey, Yiing and Ahmad, 2009). Further, understanding organisational culture will help to deal with defensive behaviour efficiently. The organisation is a social system where humans create different actions and behaviours according to the situation (Argyris and Schon, 1992). According to Spencer-Oatey and Franklin (2012) and Wagstaff and Burton-Wylie (2018), the human race, ethnicity groups and culture are significantly influencing individual behaviours. It directs individuals on how to act and behave in different situations. Defensive practice is classified as 'fear-based practice'. It is influenced by the organisational culture of defensive practice and individual emotions (*ibid*). For example, fear of the unknown and uncertainty about the future, especially with increasing working criteria and qualifications, people feel insecure that they might lose their jobs at any moment, which ends up in defensive behaviour. For example, silence or defensive actions are common in any organisation. Augoustinos, Walker and Donaghue (2014) and Secchi and Bardone (2013), stated that individuals perform defensive actions sometimes due to cultural influences. Similarly, Whittaker and Havard (2016), emphasised that the current organisational culture is more likely to create a defensive practice to protect individuals from an unknown threat. This

threat could be a change in the working status or failure to fulfil the working requirement. Thereby, defensive practices are frequently applied by employees to protect and keep themself safe (Cooper, Hetherington and Katz, 2003; Ferguson, 2005).

Defensive behaviour has been widely debated within the area of medicine, specifically medical professional personnel, due to medical malpractice complaints. Seemingly, a defensive practice might be used to cover employees' malpractice or hidden aspects. Human nature avoids confessing failure or mistakes, which is very normal to find in all professions and careers. Therefore, changing the behaviour or performance of medical staff such as nurses or doctors seems to be challenging (Babiker et al., 2014). Moreover, Harris (1987) manifested that professional workers would use defensive practices carefully to protect their careers. This implies that applying defensive practice is commonly practised to avoid consequences. Therefore, identifying the risk factors and stressors is vital to deal with the external environment efficiently. Perhaps, giving some training for employees to deal with the situations based on their best knowledge, would be useful to prevent any defensive actions. Nevertheless, organisation culture sometimes would rather be secretive than publicity. This depends on the management and their ways of controlling the organisation. Sharing information with the public could be sensitive for some people, they might be hesitant to share this information due to a lack of trust in the outsider. For example, some individuals could hold that information against them. Besides, a lack of staff abilities and skills could make the managers more cautious and secretive. As Rye (2015), stressed that political power significantly impacts the organisation. For instance, the allocation of power could mainly happen with political support (Parsons, 1963), forming group coalitions and manipulation of power for their self-interest by resolving conflicts in different organisations and vice versa (Wagstaff and Burton-Wylie, 2018). This explains why some organisations prevent publicity, to keep themselves away from the influence of political power.

2.3.5.2 Policy and Power

The role of the administration or management in the organisation involves rules and obligations, further, it is formed as a policy and guidelines (Allsop, 2018). Pawson (2006) highlighted that modern policy is the output of balancing the act between power, ideological standpoints, hierarchical privilege, and democratic obligations. This could be an indication that the policies are controlled by the people in the management and administration positions, and they use these policies to control employees. Also, O'Brien-Pallas et al. (2001) stated that

political issues, government policies and socioeconomic factors have an essential role in changing the healthcare system. In this manner, developing the nursing profession requires collaboration from several departments to create effective policies, standards, norms, and training (Trede, Macklin and Bridges, 2012). The health policies are aligned with politics (government power), and both significantly influence the development of the health profession. For example, the political power of the Florence Nightingale family helped to shape her vision and develop the nursing profession in the United Kingdom (Paradis, Hart and O'Brien, 2017). Further, Burgess and Purkis (2010) and Mason et al. (2020) stressed that policy and politics play a vital role in shaping the nursing profession. Based on NMC (2018), developing health care is constrained by the political and organisational agenda, which is considered to be challenging for the nurses and needs to be handled carefully. For example, the political and organisational policy had come to a place during COVID-19, where the type (A) hospital with specific qualifications, had been transferred to type (B) hospital with different qualifications. This has been done based on the urgency and need of the situation. This shows how the organisational and the political agenda are directly impacting the way that healthcare services are provided. Similarly, if the government and organisational policy toward supporting the nursing profession, then policies will be developed based on it that will promote nurses' integral role in the healthcare profession. This could lead to the development and further expansion of nurses including wound management nurses.

2.3.6. Profession and Decision Making

Higgs, McAllister and Whiteford (2009), asserted that decision-making could be designed based on professional roles and perceptions. For instance, physicians could see nurses as subordinates, and they might believe that the decision related to the patient aspect is their duty only without considering nurses' decisions as important as theirs. This reflects the issues of colonising the knowledge (Section: 2.3.5, page: 49). It is essential to follow the professional roles prior to making a decision, for instance, physicians have the authority to obtain patient consent for procedures and nurses are not expected to do so, yet they are asking nurses to take patients' consent and nurses still following anything doctors are saying, which could be the result of doctor power in the organisation. On the contrary, for decision-making, physicians do not accept nurses to participate, however, when it comes to their comfort, they do ask nurses to perform their duties. Sometimes, staff allocation and job rotation have to be managed by nurses' leaders, whereas doctor interference and personal preferences can lead to staff

grievances. This implies that nurses' roles and responsibilities have been defined as per decision makers' and doctors' convenience. Further, decision-making should not be based on uncertainty or individual perception, because if each nurse uses their perceptions, the quality of the services provided will vary and the chances of improving the nursing practice would decrease. Decision-making could be associated with professional boundaries such as ethical and moral principles of the profession (Section: 2.3.2, page: 41), and ongoing training, to enhance nurses' knowledge.

2.4. Leadership and Developing Nursing Speciality

Managers and leaders are performing an essential part in enhancing the efficiency of the services, through making appropriate decisions. Leadership has been explored and defined extensively by different authors based on their understanding, for instance, Seeman (1960: 53) defines leadership as:

"*Acts by persons which influence other persons in a shared direction*".

This manifests that leaders have an essential role in convincing or influencing others, so employees will be pleased to follow similar beliefs as their leaders'. Whereas employees have been described as the followers of leaders (Gopee and Galloway, 2017). Several theories have addressed the leader and follower's relationships, those theories such as authentic leadership, servant leadership and transformational leadership *(ibid*). Squires and Northouse (2018) stated that individuals attempt to achieve a common goal through leadership influences. When the leaders presume there is a necessity to develop TVNs for organisational and societal benefits, then they would attempt to influence employees to collaborate with the new changes in policies and their practice. The role of leadership and administration was highlighted since the concept of the nursing profession evolved, as Florence Nightingale reinforced the administration's duty toward maintaining a high quality of care (McDonald, 2017). Nursing administration and leadership are highly recommended to assist in maintaining high standards of health care. Having an effective leader is important to inspire the employees to accomplish the task or achieve the goal and deal with different situations. The role of nursing leaders is focused on managing and influencing the majority of the nurses (Cowden, Cummings and Mcgrath, 2011) thus facilitating the achievement of organisational goals effectively. Likewise, Carragher and Gormley (2017) and Duncan, (2019) highlighted the importance of progressive nursing leadership in facilitating effective changes, further playing a fundamental role in developing strategies for managing wounds. By identifying the patient's needs and using

alternative approaches to effectively manage the wound without complication by making a plan to meet that goal. In contrast, ineffective nurse leaders could drive the organisation to failure and, hence, will have a negative impact on patient care (Murray, Sundin and Cope, 2018; Keogh, 2013; Gandolfi and Stone, 2018). If the leaders are incapable of making effective decisions, the organisation will fail to achieve its goal. Traulsen and Bissel (2004), Oberhuemer (2015) and Aukett (2017) argued that nurses have limited power to influence other health professionals due to their low social status. The nursing profession has been historically undervalued due to the female dominant role in the profession and gender discrimination or inequalities which leads to low social status. This entails that nursing leaders lack the power and hence, might not be able to give the expected support for the nurses to initiate a new nursing speciality related to skin and wound management.

2.5. Professional Development

This study illustrates how the professionalisation of nurses could lead to a significant change in the nursing career and healthcare services within the practice boundary. For example, professional development aims to deliver high standards of services by promoting the efficiency of the training and education of the discipline through qualified staff (Taylor et al., 2011). Those qualified staff are the key aspect of professional development. Conducting different workshops related to professional development training is considered a good exercise to increase the understanding associated with the new speciality / TVNs (Berndt et al., 2017). In this context, nursing professional development seeks to develop the skills and knowledge of the nurses related to skin integrity and wound management without referring to other health professionals. This will enable them to think critically and analyse the situation based on their best knowledge and experience for making appropriate decisions.

Both individual and system competencies are significant to strengthen professional development, by following key factors such as urgency and need for development, acquiring new knowledge and skills, professional recognition and achieving a high level of accreditation (Munro, 2008). Providing training for nurses might lead to the successful adoption of the changes in their role. This training required more resources and support from the administration for nurses’ progress, including access to advanced training, equipment, and technology, which can enhance their practice. In contrast, inadequate training often ends up as a barrier to innovation and creativity (Joy, Bielby and Searle, 2015). Despite that, achieving a high level of professional development for nurses is not easy, due to organisational and employment

barriers (Al-Ma'aitah and Momani, 1999). For instance, conflicts, burnout, and anxiety are usually developed from work demands, assignments and daily routine activities (Section: 2.2.1.1, page: 38). Also, the profession could lead to conflict between health professionals, which leads to staff dissatisfaction. Although professionalising the staff and professional development appears beneficial. Yet, there is still some ambiguity regarding how effective and realistic it is to apply them. Jeris and Armacost (2002) and Munro (2008), asserted there is an explicit contradiction between the purpose of professional development in terms of profession and practice. For example, individuals are not sure if they have to do good for society by ignoring being good to themselves. If nurses are providing comprehensive care for all patients, then they have to suffer, for example, most of the time nurses are ignoring their tea break because of staff shortages. According to Hammond and McLaughlin (1995), professional development must be integral to the policy and guidelines. In addition, the World Health Organisation (2006b) and AbuAlRub and Foudeh (2017) highlighted that effective health policy has a direct impact on midwives' and nurses' duties, which could elevate individuals professionally. In contrast, ineffective policies could suppress individuals professionally. For example, the Ministry of Health gives less consideration to nursing training and this in turn will adversely affect their professional development, due to a lack of updated knowledge, hence, nurses will have a lack of ability to exert their influence in organisations. This illustrates that professional development is highly linked to policy, training, and knowledge. Therefore, applying professionalisation theory would enhance the understanding of nursing as a career to build societal trust, which could be achieved through enhanced nursing power and leadership support, further the development of policy along with the application of training.

2.6. Tissue Viability Nurses

Many patients are suffering from skin problems including wounds. Dealing with wounds is not desirable by the health personnel however, managing non-healing wounds is considered to be more complicated to achieve. Without proper wound care, wounds can become infected, leading to further complications and potentially more serious health issues, this could cost a massive amount annually due to spending on specialised nurses to provide wound care for patients which in return increases the burden on the health sector, as mentioned in chapter one (Section: 1.3, page: 8). Therefore, nurses must have the knowledge along with skills to enhance their ability to identify other health problems that could worsen the wound healing process. In this perspective, wound management is a systematic strategy that includes

prioritising the steps to facilitate wound healing and then improve skin condition (Alvarez et al., 2007). Based on Humphries (2015), the ageing population is growing dramatically, which increases the burden on nurses and health services. Consequently, the demand for TVNs increased to manage complicated wounds that are associated with ageing. The role of TVNs is under persistent change based on the needs of the healthcare and community. This makes their role evolve frequently according to healthcare requirements and patients' needs. Thus, changes include updating the policy and regulations, with the provision of financial and managerial support for successful results. Inspite of that, in a study conducted in 2011 among TVNs regarding their role, the participants stated that their role exceeds being a health practitioner, otherwise, they are playing the role of a lecturer or infection control (Hecke et al., 2011). Overall, the system necessitated some modifications to reduce the workload and re-designing the role and responsibilities of TVNs.

Macheridis and Paulsson (2019) highlighted that the profession gives individuals the power to make effective decisions. Furthermore, Bourgault and Parent (2008) and Hampton et al. (2009) emphasised that professional knowledge and skills related to the career are transferred to principles that guide individuals in decision-making. Friman et al. (2010) underlined that one of the main responsibilities of nurses is to identify and assess the wound and then make the best decision accordingly. Hence, TVNs own special knowledge and skills related to skin and wounds, which give them the ability to decide effectively in their area of speciality. According to Finnie and Wilson (2003), the competency of the TVNs has developed three core domains as illustrated in Figure 2.7. These domains aim to build an effective staff member who can identify the issue and decide effectively based on scientific evidence. Any nursing speciality requires competent and knowledgeable staff to undertake the role within any discipline (*ibid*). Ousey et al. (2015) and Doughty and Sparks (2016), stated that dealing with skin problems and managing wounds is a complex process that requires the identification of the characteristics of the healing process. Therefore, the TVNs need a range of skills to be able to lead and improve skin integrity.

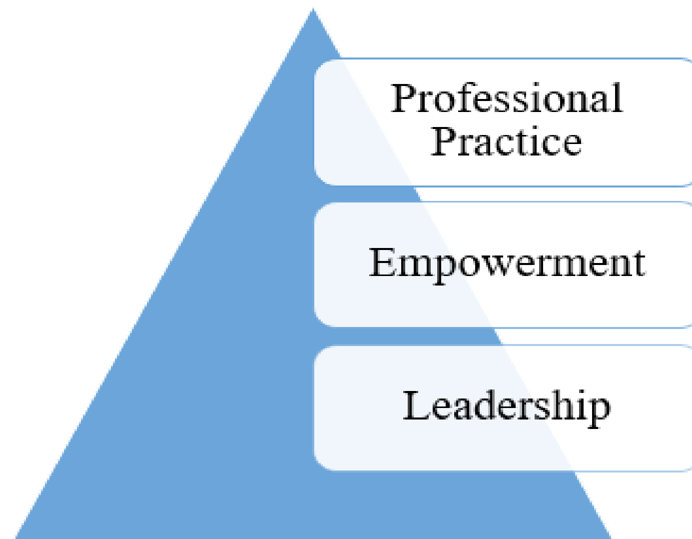


Figure 2.7: Core Domains for TVNs (Finnie, 2003)

Based on The International Alliance of Patients Organisations (2007) as cited by Ousey et al. (2015), patient care has five main aspects as shown in Figure 2.8. These aspects if covered by the TVNs, the outcomes for patients will be improved. Additionally, TVNs aim to share their knowledge with other health practitioners to increase their understanding of skin problems. Also, educating patients about the care pathway is important to increase their awareness and engage them to overcome the knowledge gap and maintain healthy skin. However, several factors need to be addressed to adapt to the new speciality in tissue viability, by developing a new policy, training, education, cultural adaptation, and other aspects that must be considered as will be explored later.

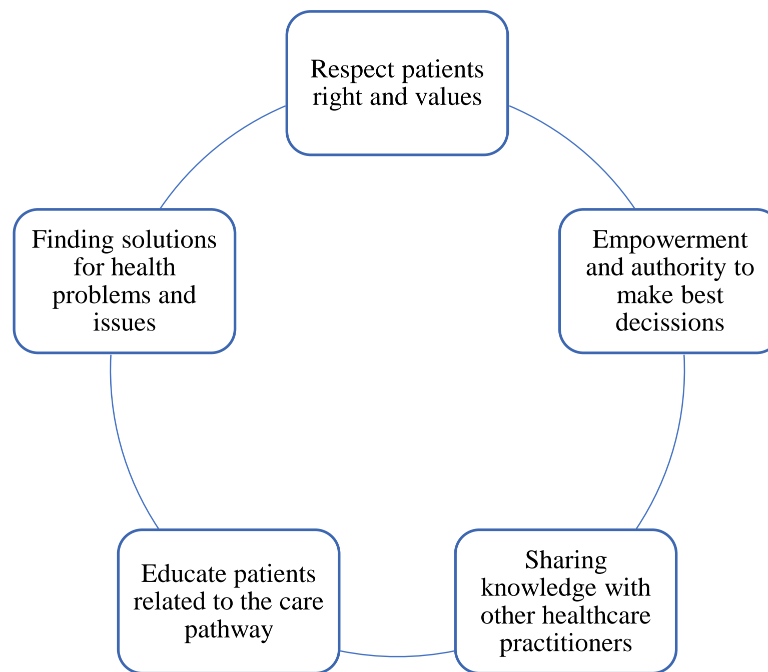


Figure 2.8: Main Aspects of Patient Care (The International Alliance of Patients' Organisations, 2007)

Based on Adeniran et al. (1995), a high rate of wound complications and mismanagement is shown in a study conducted on patients who were treated by TVNs in 1980. Despite that, it has been more than 40 years of conducting this study, but the same problems exist today. Ousey et al. (2014), argued that the effectiveness of the TVNs cannot be measured accurately due to a lack of reliability and validity of the applied tools. This shows there are gaps in the role of the TVNs, which might be an indication of a lack of appropriate policy or deficiency in the system, lack of resources, or organisational problems. Flanagan (1998), White (2008) and Ousey et al. (2014) argued that the role of the TVNs is complex and not well designed and that the nurses themself cannot differentiate between the roles of advanced and specialist nurses. Furthermore, Dutton, Chiarella and Curtis (2014) asserted that the role of TVNs developed haphazardly with little understanding of tissue viability and skin care. A study conducted in Scotland magnifies that is one of the main challenges that TVNs are facing, related to the staff's inability to understand their role clearly, which misleads them while performing their job (Finnie, 2001). As a result, those nurses found themselves professionally isolated and avoided participation in meetings or conferences to avoid embarrassment due to a lack of understanding of their roles. Moreover, another study performed by Ousey et al. (2015)

argued that TVNs have no standards recognised for their job description, along with this, they are not aware of their job title, some consider themself as 'Lead Nurse Tissue Viability, Wound Care Nurse or Tissue Viability Nurse Specialist' which create confusion and leads them to be internationally not acknowledged by some authorities. Furthermore, TVNs do not have an accepted defined scope of practice outside of nursing (White, 2008). This ambiguity could produce conflict between TVNs and healthcare workers or patients. Given the implication, that the role and job title of TVNs is poorly understood by the nurses themselves, hence, it will be difficult for other health personnel to accept this speciality as leading for effective change. This also might result in resisting the new nursing speciality in Kuwait, Qatar, Jordan, and Egypt, due to unfamiliarity with their role and job description.

2.7. Development of the Nursing Profession

History has witnessed the role of the female in caring and healing wounds. This started when the witches were considered as healers, and then after the Roman Catholic religious evolution, the role of the witches as healers was abolished. After that, the midwives started and they are known as a female who travels between the villages to help with the healing process by using remedies and helping females while giving birth (Bhowmik, Biswas and Ananna, 2020). The roles of caring and healing were led by a female who later became an essential figure in the nursing profession. The profession is described when a group of members works in a certain field within a specific framework and theoretical knowledge. This framework of sociology and professionalisation assists nurses' practice to evolve, by following the same code of ethics, education, and training. Antohe et al. (2016) acknowledged that the nursing profession is focused mainly on medical knowledge and clinical skills.

Initially, the nuns were performing the role of the nursing for religious purposes in the church, and they were caring for patients during the war (Paradis, Hart, and O'Brien, 2017), still, their work was not organised well and lacked regular training. Nursing education was started effectively by a physician called Valentine Seaman. The evolution of the nursing profession is shown in Figure 2.9. Valentine Seaman started to give lectures for females who were interested in maternity studies. Following that, Dr Joseph Warrington wrote a book related to nursing careers and duties for those who were interested in nursing (Coopen, 1972). Later, the idea for seeking a modern nursing profession was developed by Florence Nightingale. Ms Nightingale was an English affluent woman, who came from a political family (Paradis, Hart

and O'Brien, 2017). She led a group of females in the Crimean War in 1854, to care for the British wounded soldiers and then, she started the first nursing school in 1860 (Bostridge, 2015). Moreover, Mary Seacole established the British Hotel for Soldiers in 1855 (Sofer, 2016), which made the role of nurses more remarkable. After that, the nursing profession transferred worldwide to create qualified nurses with high standards. For Ms Nightingale, nurses' duties are not limited to caring for patients only, but they extend to other areas such as ensuring social well-being and acting as healers or carers in society. Florence Nightingale stressed that nurses' role is a combination of health promoters and educators, political and social advocates, leaders, and researchers (Ferguson, 2004), which also reflects the role of TVNs.

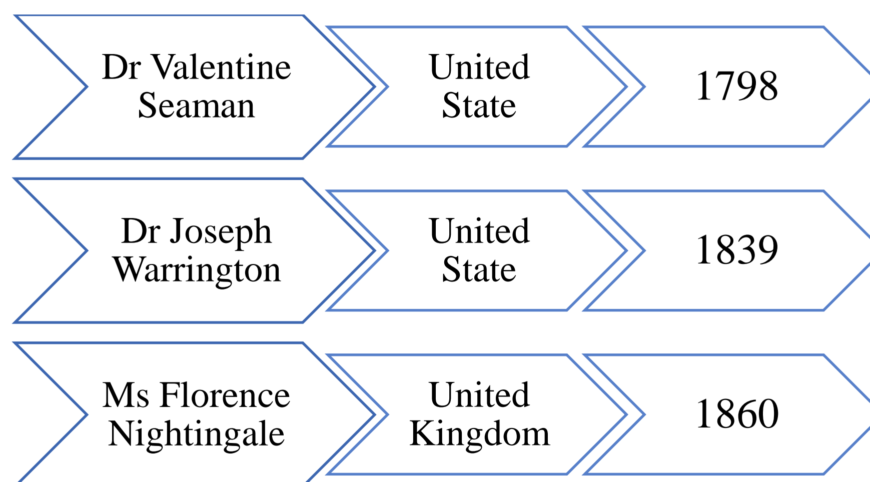


Figure 2.9: Beginning of Nursing Education

2.8. Professionalisation and Nursing

Hallam (2002) stated that nursing as a profession developed over the years which helped to establish a distinctive social status and identity. However, Adams and Miller (2001) and Meerabeau (2005) argued that nursing is a semi-profession, which is associated with the class structure. This concept has been associated with nursing that is rooted in the profession along with patriarchy and other issues that will be explored in this chapter. From a sociological perspective, gender and profession are related to a broader concept which is known as patriarchy (Witz, 2013). Hartmann (1981), Cockburn (1981) and Walby (1989) highlighted that patriarchy used to focus on the gender issues related to male domination and females as subordinates (Section: 2.3.3.1, 2.3.3.2, page: 43-45). Further, nursing perceptions and roles could change positively after applying the professionalisation framework, which could help to develop a new nursing speciality by seeing nurses as a unique career with new knowledge

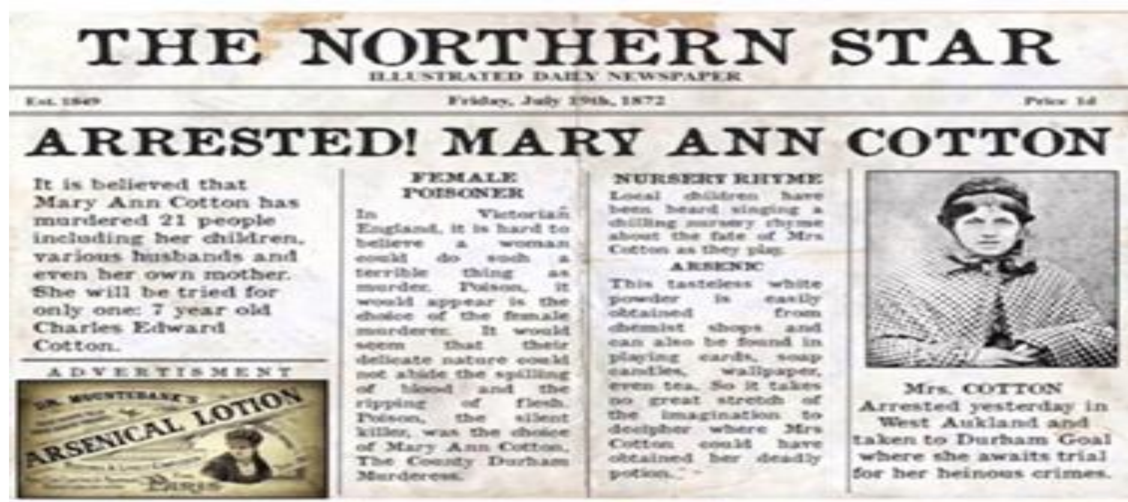
(Wall and Hallett, 2018). According to Saarikoski et al. (2018), a nurse's professionalisation enhances the scope of the knowledge and shared individual experience. Furthermore, it assists in building nurses' confidence, self-direction, and independence in order to develop trust in the nurse's performance and practice. Freidson (2001) highlighted that unique knowledge and skills enhance trust in the profession. Therefore, believing in the knowledge, experience, and skills would improve the position of the nurses and elevate their professional status, then eventually enhance the trust in the profession (*ibid*). For example, changing the theories and models of the nursing syllabus, and developing new definitions and knowledge of nursing practice will strengthen the nursing profession (Brunner and Kada, 2010).

The development of a new profession has a prerequisite related to the qualitative aspect that needs to be addressed (Oberhuemer, 2015). For example, there is a necessity to develop specialised nurses to fill the gap in healthcare services such as wound management and skin integrity. However, nursing education is diverse from one country to another with multiple programs, this variation of knowledge could affect the quality of the services provided. Some countries give more consideration to nursing education and mentoring to develop skilful and knowledgeable nurses (Antohe et al., 2016). Adversely, education outcomes for nursing studies in Kuwait lack efficiency due to outdated syllabuses as well as the infrastructure. In the same context, Zabalegui et al. (2006) asserted that the academic development of nursing is still in progress. For example, the lack of higher degrees in nursing such as Masters' and Doctorate degrees in Kuwait, might create a hurdle for innovation and progress. Consequently, it could affect the development of TVNs and expand new areas of nursing specialities in Kuwait, Qatar, Jordan, and Egypt. However, Saleh et al. (2019) argued that nurses with higher degrees are less knowledgeable in dealing with pressure ulcers than those nurses with Baccalaureate degrees. Therefore, it is not a criterion to have a higher qualification to develop TVNs.

2.9. Professional Profile and Social Status

According to Macheridis and Paulsson (2019), the profession helps to maintain a high level of education and it is supported by certain skills that contribute to building a work structure. This high level of education can assist in developing a professional profile by developing own values, goals, mission, vision, and knowledge base, to enhance societal understanding of the professional role in the discipline (Oberhuemer, 2015). However, social status enhances the development of professionalisation strategies and professional profiles by using an interpretation of the available information to build the character of the discipline based

on certain concepts (*ibid*). Professionalisation is considered as a social phenomenon that shapes the social status of the profession (Helsper and Tippelt, 2011). For instance, a nursing college in Kuwait accepts students with low grades (60%), in this manner a negative social perception developed about the nursing profession along with a lack of trust in the nursing knowledge. As a result, the nursing profession status in the Middle East particularly in Kuwait, Qatar, Jordan, and Egypt is not well acknowledged compared to other health professionals. As mentioned earlier due to the lack of appropriate policy, political factors or nepotism and socio-cultural factors. Further, history represents nurses inappropriately such as Mary Ann Cotton as shown in Figure 2.10.



THE NORTHERN STAR

ILLUSTRATED DAILY NEWSPAPER

Est. 1849 — Friday, July 19th, 1872 — Price 1d

ARRESTED! MARY ANN COTTON

It is believed that Mary Ann Cotton has murdered 21 people including her children, various husbands and even her own mother. She will be tried for only one: 7 year old Charles Edward Cotton.

ADVERTISMENT

FEMALE POISONER

In Victorian England, it is hard to believe a woman could do such a terrible thing as murder. Poison, it would appear is the choice of the female murderer. It would seem that their delicate nature could not abide the spilling of blood and the ripping of flesh. Poison, the silent killer, was the choice of Mary Ann Cotton, The County Durham Murderess.

NURSERY RHYME

Local children have been heard singing a chilling nursery rhyme about the fate of Mrs Cotton as they play.

ARSENIC

This tasteless white powder is easily obtained from chemist shops and can also be found in playing cards, soap candles, wallpaper, even tea. So it takes no great stretch of the imagination to decipher where Mrs Cotton could have obtained her deadly potion."

Mrs. COTTON

Arrested yesterday in West Aukland and taken to Durham Goal where she awaits trial for her heinous crimes.

Figure 2.10: The First Female Killer (Gurian, 2014)

Mary Ann Cotton was a British nurse, who is considered as the first female killer (Gurian, 2014). Another British nurse was Mary Ann Bevan who was working in circuses (Danzig, 2006) as shown in Figure 2.11. This negative publicity affects people's perception about the nursing profession and reflects in the society's unacceptance of the profession, leading to low social status. Moreover, the media undermine the role of nurses compared to other health professionals such as doctors who are more highlighted or praised in case of success including efforts during COVID-19.

Figure 2.11: Mary Ann Bevan (Danzig, 2006)

Media plays a crucial part in destroying the image of nursing and negatively influencing people's thoughts about the nursing profession. Some famous programs and dramas present nurses as naughty females such as the Skechers advertisement in August 2004 as shown in Figure 2.12, the advertisement played by Christina Aguilera, in which she performed the role of nurse inappropriately (The Truth About Nursing, 2004). In the same year as shown in Figure 2.12, Dr Phils also stated that:

"Cute little nurses who are out to seduce and marry physicians, because that's their ticket out of having to work as a nurse".

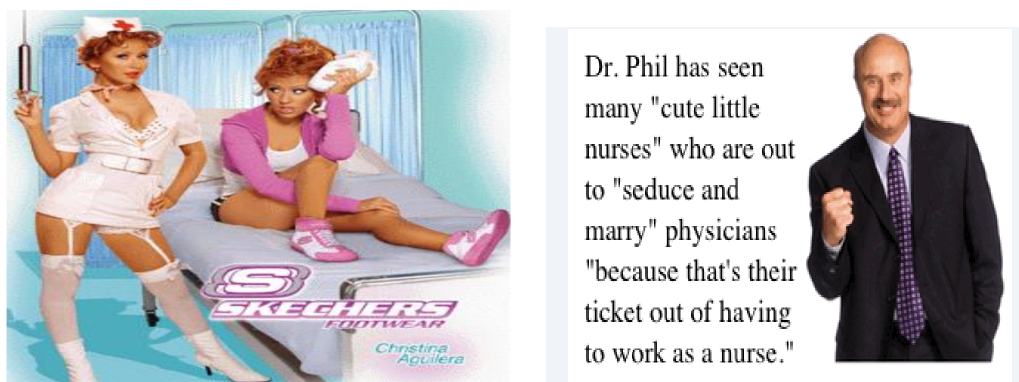


Figure 2.12: Christina Aguilera and Dr. Phil (The Truth About Nursing, 2004)

Another famous program Dr OZ in 2010 as shown in Figure 2.13 presents Angel Williams dancing in a short nurse dress (The Truth about Nursing, 2010). These celebrities or programmes are misleading the new generation about the nursing profession, which undesirably affects the status of the profession. Moreover, it shows a stereotypical lens for perceiving the image and role of nursing in society. Also, in Kuwait, some dramas represent female nurses inappropriately (Allaqetta, 2005) which is not acceptable in the conservative society as in Kuwait.

Figure 2.13: Dr. OZ (The Truth About Nursing, 2010)

Infact, this makes the status of the nursing profession low and culturally unacceptable, especially in conservative societies. Apart from that, it impacts the societal perception adversely regarding nursing duties, where they are considered as helpers or semi-profession. Also, in the case of Kuwait, several incidents occurred where patients or their relatives treated nurses inappropriately by using verbal violence and sometimes it may even reach physical violence (Elbarazi et al., 2017), taking advantage of that the majority of nurses are non-Kuwaiti nationals and the system supporting them most of the time due to Wasta (Section: 2.3.4.2, page: 48). Further, the cases of nursing violence in Kuwait are extremely increasing. However, in 2015 the Ministry of Health set a new policy to support the health worker against any violent action, by giving a fine to patients or relatives. However, patients and relatives are still fighting with nurses because of the low social status of nursing. Further, lack of nursing administration support and fear of termination of service prevents nurses from complaining or claiming their rights. In return, this hesitation or fear to ask for their rights makes nurses' professional status low. In addition, this low status leads to a lack of trust in nursing capability and ability to make decisions related to skin integrity and wound management. Therefore, introducing TVNs would be challenging due to a lack of trust and misperceptions about the nursing role.

2.10. Nursing Profession in Jordan, Egypt, Qatar, and Kuwait

2.10.1. Nursing Profession in Jordan

The nursing profession in Jordan has undergone significant development over the years. Prior to the establishment of formal nursing education programs, nursing in Jordan was mainly carried out by individuals who learned the skills through apprenticeship or job training. However, in 1953, the Jordanian government began to recognise the importance of formal nursing education and nursing schools were established (Zahran, 2012). In the 1960s, Jordan collaborated with the World Health Organisation (WHO) to develop a nursing curriculum to meet health international standards (Kronfol, 2012). Several universities and colleges in Jordan offer nursing education at the diploma, bachelor's, master’s, and doctoral levels. Nurses in Jordan receive education and training that is comparable to international standards, and they are required to be licensed and registered with the Jordanian Nursing Council (Hayajneh, 2009; Zahran, 2012). The Jordanian Nursing Council is responsible for regulating the nursing profession and ensuring that nursing education programs meet national and international standards (Shamieh et al., 2020). The development of the nursing profession in Jordan has been substantial, with improvements in education, specialisation, and professional recognition. However, like other countries, nurses in Jordan face several challenges such as increased workloads due to resignations which lead to nurses’ shortage. Amarneh et al. (2021) and El-Bahnasawy, Al Hadid and Fayed (2021) have discussed that nursing in Jordan and Egypt are seeking work opportunities in Gulf countries, for higher living standards and better salaries. Likewise, Armstrong et al. (1994) highlighted that Jordanian nurses are leaving to work in Gulf countries, which creates chaos due to nurses’ shortage. According to Oweis (2005) and AbuAlRub (2007), over the years nurses have been in a subordinate position and they struggle to obtain community respect. Further, nurses in Jordan have low social status and the parents or spouses disapprove of their daughters or wives being in this profession due to cultural boundaries such as females not being allowed to work the night shift. However, Jordanian workforce nurses reported less than one percent of foreign nurses (Al-Ja'afreh, 2019). This shows that the nursing profession is relying on Jordanian nationals.

2.10.1.1. Specialised Nurses and Wound Management in Jordan

Jordan has implemented policies and programs aimed at improving access to healthcare and promoting better health outcomes for its population (Kronfol, 2012), one of these programmes is wound management. Wound management in Jordan is primarily provided by

healthcare professionals in hospitals, clinics, and other healthcare facilities. The Jordanian Ministry of Health has established guidelines and protocols for wound management and healthcare professionals in the country are trained to follow these guidelines (Tubaishat, Aljezawi and Al Qadire, 2013). Despite that, there are still challenges in providing comprehensive wound management to all patients (Omran and Obeidat, 2015). These challenges include limited resources and a lack of awareness about the importance of appropriate wound management. However, efforts are being made to improve wound care services in the country, including increased training for healthcare providers and enhancing the role of wound management nurses. Specialised nurses in tissue viability in Jordan are registered nurses who have completed additional training and certification in wound care management. This training is provided by hospitals and universities. It includes courses in wound assessment, diagnosis, treatment and prevention of wound infection and further patient education to improve the wound healing process (Tubaishat, Aljezawi and Al Qadire, 2013; Saleh et al., 2019).

2.10.2. Nursing Profession in Egypt

Nursing in Egypt began in the late 19th century by British and French trained nurses, who delivered midwifery training for females in the country (Ma et al., 2012). It was followed by the establishment of the first nursing school in Cairo in 1952 (Abou Hashish and Fargally, 2017). In the following decades, more nursing schools were established in Egypt, these schools were managed and regulated by the Ministry of Health, and the curriculum was expanded to include both theoretical and practical training. The country offers multiple nursing programmes and specialities in nursing. After completing nursing education, the nurses must pass a national licensing exam in order to practice. Once licensed, they can work in various healthcare services. Further, nurses are required to participate in continuing education programs in order to maintain their licensure. These programs help nurses stay up to date with the recent technologies in healthcare and provide opportunities for professional development. Nursing in Egypt is progressing, and there is growing recognition of the important role that nurses play in the healthcare system. Despite that, Elewa and El Banan (2019) assessed there is a lack of trust in nursing knowledge in both government and private sectors. Further, nurses are not well-compensated for their work and face other challenges, including a shortage of nursing and inadequate training opportunities. Many nurses in Egypt have also reported experiencing workplace violence (Kabbash and El-Sallamy, 2019). Also, similar to Jordan, nurses in Egypt are seeking work opportunities in Gulf countries for better salaries (Amarneh et al., 2021; El-

Bahnasawy, Al Hadid and Fayed, 2021). The nursing workforce is covered mainly by Egyptian nationals, yet the demand for nurses in Egypt is increasing significantly, due to the high population growth (Figure: 1.6, page: 14), particularly in rural areas where access to healthcare is limited. Therefore, this led to a significant shortage of qualified nurses in the country and put a strain on the available nursing staff further increasing their workload. The government has taken steps to address the shortage of nursing staff, by increasing the number of nursing schools to encourage more students to pursue careers in nursing (Hashish, Aly and Alsayed, 2020).

2.10.2.1. Specialised Nurses and Wound Management in Egypt

The Ministry of Health developed a new programme related to specialised nurses in wound management and skin care, this programme was adopted from the Canadian Association of Wound Care and introduced in 2018 (Awad and Hewi, 2020). The program aims to improve the prevention and management of chronic wounds (El-soudany, 2018). The program provides training and education for healthcare professionals, including specialised nurses, on evidence-based wound management practices. Several universities and nursing schools in Egypt offer specialised nursing education programmes related to wound management. These programmes provide nurses with the necessary knowledge to improve wound management and facilitate the healing process for patients. This includes both theoretical and practical training on wound assessment, treatment, and prevention. The Egyptian Nursing Syndicate (ENS) provides ongoing education and professional development opportunities for specialised nurses in wound management (Bassiouny and Elhadidy, 2022). The ENS offers courses, workshops, and conferences on wound care and provides certification for nurses who complete specialised training in this area.

2.10.3. Nursing Profession in Qatar

Nursing in Qatar has seen significant growth and development in recent years, with the expansion of the healthcare sector and the increasing demand for nursing in the country. It is regulated by the Qatar Council for Healthcare Practitioners (QCHP), this council is responsible for the licensing and registration of nurses and other healthcare professionals (Nashwan et al., 2017). The QCHP ensures that nurses meet the required standards of education and practice before they are granted a licence to practise in Qatar. The Hamad Medical Corporation (HMC) is the largest employer of nurses in Qatar, with over 7,000 registered nurses working in their

healthcare facilities (Musa, Mohamed and Selim, 2020). The HMC provides a range of nursing services, including medical-surgical nursing, specialised nurses in skin and wound, paediatric nursing, emergency nursing and critical care nursing. In order to meet the growing demand for nursing professionals, Qatar has invested in the education and training of nurses. The country has established several nursing programs, including the College of Nursing at the University of Qatar, the Qatar University Health Sciences College, and the Nursing Education Centre at the HMC. However, similar to Kuwait the country is suffering from nurses shortage (Efendi et al., 2020). The composition of the nursing workforce is shown in Figure 2.14. Furthermore, Qatar has also attracted nurses from other countries to work in the country. By providing high salaries and opportunities for career advancement. Several nurses from the Philippines, India, Jordan, and other countries have come to work in Qatar (Al-lenjawi et al., 2022). In Qatar, the nursing profession is led by foreign nurses (Tieleman and Cable, 2021) which could be an indication there is a lack of trust in the nursing profession.

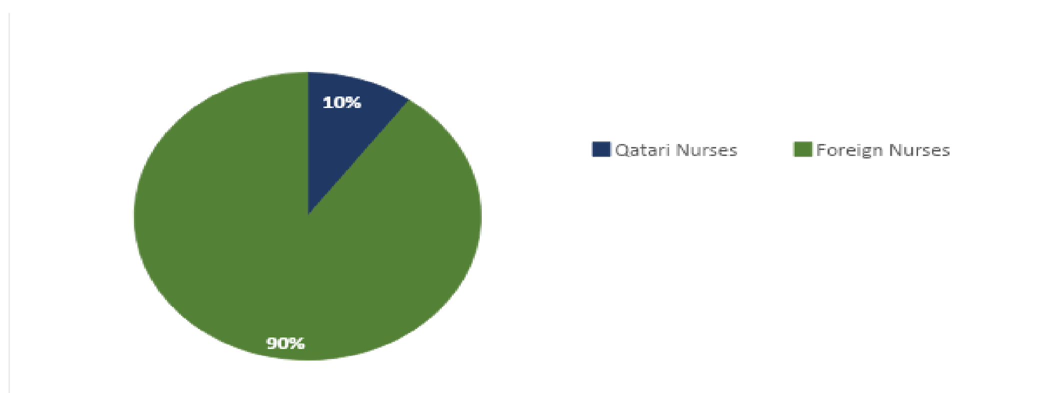


Figure 2.14: Composition of Nursing Workforce in Qatar (Statistic of nurses in Qatar, 2022)

This high number of foreign nurses could face several challenges related to the nature of the work and the healthcare system, along with the social and cultural context which might affect their practice. Some of the key challenges for nurses in Qatar include a multicultural environment. This diversity with different traditions and cultures would affect nurses' practice, in which they might face challenges in communicating with patients who speak different languages or have different cultural backgrounds. There are certain cultural and social norms regarding gender roles, which can impact the practice of nursing. For example, male nurses may face challenges in providing care to female patients or may be limited in their career opportunities due to gender roles. Therefore, nurses need to be able to provide culturally

sensitive care and communicate effectively with patients and their families. Also, Qatar, like many other countries, faces a shortage of nurses, particularly in speciality areas such as critical care and oncology. This shortage can impact the quality of care provided to patients and put additional pressure on nurses who are working in understaffed departments. Addressing these challenges requires a comprehensive approach that involves providing adequate staffing and providing ongoing education and training opportunities. Additionally, addressing cultural and social norms related to gender roles could help to promote gender equity and create a more inclusive workplace for nurses.

2.10.3.1. Specialise Nurses in Skin and Wound in Qatar

The development of the healthcare system in Qatar has been a major priority for the country, with significant investments made in both the public and private sectors, as well as in medical research and education. The country focuses on improving patient satisfaction levels and positive health outcomes (Suliman et al., 2018). As well as improving wound management as an essential component of the country's healthcare system. Wounds are a common medical condition that can lead to complications if not managed appropriately (John, Kim and Kelly, 2018). Therefore, Qatar's healthcare system has several programs and initiatives to ensure optimal wound management (AlQahtani, 2016). Also, the country has trained TVNs to provide optimal care to patients with complex wounds (AlQahtani, 2016; Nashwan et al., 2017). Those nurses received external training from Canada to improve wound management practice, through assessment, diagnosis, and treatment of wounds, further preventing wound deterioration.

2.10.4. Nursing Profession in Kuwait

Kuwait is one of the countries that struggle to develop a new nursing speciality such as TVNs. Nurses act within their scope of practice that does not give them the authority to decide on a treatment plan. For instance, nurses are considered as doctor assistants who must obey doctor instructions without participating in the treatment plan or decision (Al-Kandari and Ogundeyin, 1998). The nurse’s main role is limited to providing basic nursing care such as giving medication, assisting a doctor in the care, bed making, checking vital signs, and monitoring intake and output. It also reveals that doctors are considering nurses lower than them academically and practically as well as financially. Doctors sometimes ask nurses to serve them tea. Moreover, they considered nurses merely as clerks to write for them whether meeting

agenda in the weekly unit meeting or writing on their behalf in physician notes so when they come, they just need to add their stamp. In some ways, this illustrates that doctors are not trusting nursing knowledge, and also not giving them the chance to participate or decide on the patient treatment plan. In this concern, the issues that challenge nurses in Kuwait are similar to other countries such as the shortage of nursing staff and work overload. As it stands, the healthcare delivery department is one of the areas which is occupied mainly by foreign staff (Kuwait Ministry of Health, 2004). According to the Kuwait Department of Nursing Services (2004), as cited from Al-Kandari and Thomas (2008), the total number of Kuwaiti national nurses represents 10% of the total number of nursing professionals. Further, Kuwaiti nurses' numbers are gradually decreasing as presented in Figure 2.15. Amongst 22,000 nurses in the country, both male and female Kuwaiti nurses are only 6% of the overall workforce. To overcome this shortage the M.O.H. mainly recruits from India, Egypt, Jordan, and the Philippines (Al Otabi et al., 2004). Indeed, the preferences for recruitment in Kuwait were from Arab and Muslim countries (Al-Jarallah et al., 2021). Despite that, after the Gulf War in 1990, the Kuwaiti government started recruiting mainly Egyptian and Indian nurses (Dalayon, 1990; Al Otabi et al., 2004), instead of Palestinian, Iraqi, and Syrian. Besides, due to the Arab Spring and sanctions; the government banned recruiting nurses temporarily from Syria, Lebanon, Iran, and Pakistan. Being a nurse in Kuwait or other countries is surrounded by several challenges and applying this research would help to understand those challenges in order to develop a new nursing speciality in the country.

Like other countries, nurses are in demand in Kuwait and the country suffers from staff shortages due to inadequate distribution of nurses and mismanagement (Al-Kandari and Lew, 2005). Also, the country suffered from internal and external nurses’ turnover, which affects the healthcare services and the quality of the healthcare delivered (Alotaibi, 2008; Al-Kandari and Lew, 2005). Similarly, many resignations and hospitals lack nurses due to COVID-19 (AlKandari et al., 2022). The nurses are required to provide health services in six government health regions, apart from the AlAhmadi Health region which is managed by the Kuwait Oil Company along with the Ministry of Health. The overall nursing profession structure in the country is represented in Figure 2.16. Therefore, with this shortage, the Ministry of Health cannot achieve its target by 2035 (Section: 1.7.1.1, page: 21). It also might be challenging for the M.O.H. to develop a new nursing speciality with the high rate of nursing shortage. These factors affect the nursing care delivered to patients and could deteriorate patients' condition who suffer from chronic wounds. Further, with the shortage of nurses, the country cannot

provide adequate staff to cover the massive bed capacity in the new medical facilities according to the M.O.H. vision by 2035 (Salman et al., 2020). This shows inefficient planning, in which the M.O.H. invests in the buildings and technologies without considering the nursing shortage. Those new buildings cannot operate without enough nurses. Moreover, with this staff shortage and increasing workload, nurses might lose the enthusiasm to develop a new speciality. Hence, the Ministry of Health in Kuwait needs to look at new workforce planning strategies by setting a goal along with the relevant policy, to achieve the organisational outcomes and assist in managing the issues associated with staff shortage.

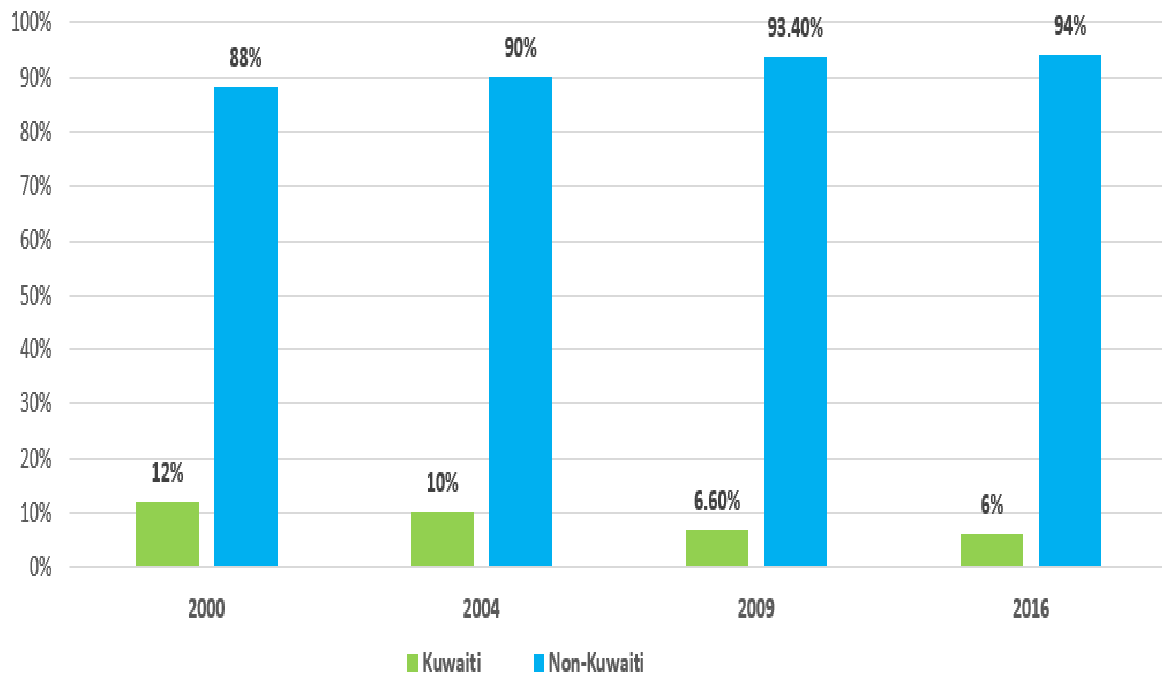


Figure 2.15: Total Number of Kuwaiti and non-Kuwaiti Nurses in 2000, 2004, 2009, and 2016 (Kuwait Department of Nursing Services, 2004; WM, 2019)

ORGANISATION STRUCTURE FOR NURSING DEPARTMENT

CONFIDENTIAL
Rev. : 0 Draft
Date : 05 Jul 2020

NURSING SERVICE & ADMINISTRATION
Director of Nursing

Superintendent of Planning and Training

Superintendent of Coordination and Follow up

Jahra Region
Regional Director of Nursing

Ahmadi Region
Regional Director of Nursing

Farwaniya Region
Regional Director of Nursing

Hawally Region
Regional Director of Nursing

Asema Region
Regional Director of Nursing

Mubarak Al-Kaber Region Regional Director of Nursing

Sabah Medical Region
Regional Director of Nursing

Central Department
Regional Director of Nursing

Jahra Primary Health Centre
Director of Nursing

Jahra Hospital
Director of Nursing

Ahmadi Primary Health Centre
Director of Nursing

Adan Hospital
Director of

Farwaniya Primary Health Centre
Director of Nursing

Farwaniya Hospital
Director of

Hawally Primary Health Centre
Director of Nursing

Mubarak Hospital
Director of Nursing

Asema Primary Health Centre
Director of Nursing

Amiri Hospital
Director of Nursing

Mubarak Al-Kaber Primary Health Centre
Director of Nursing

Al Jaber Hospital
Director of Nursing

Maternity Hospital
Director of

Al Sabah Hospital
Director of Nursing

Al Razi Hospital
Director of Nursing

Physical Medicine Hospital
Director of

Chest Disease Hospital
Director of

Ibnsina Hospital
Director of

Kuwait Cancer Control Center Hospital
Director of Nursing

Kuwait Center for Mental Health Hospital
Director of Nursing

Palliative Care Center
Director of

Sabah Al Ahmed Center for Urology Hospital
Director of

Infectious Disease Hospital
Director of Nursing

Al Rashid Allergic Center Hospital
Director of Nursing

Zain Hospital
Director of Nursing

Addiction Treatment Center Hospital
Director of

NBK Children Hospital
Director of Nursing

Jaber Al Ahmed Center for Nuclear & Molecular Imaging Hospital
Director of Nursing

Asad Al Hamad Dermatology Center Hospital
Director of

Public Health Department
Director of Nursing

Geriatric Department
Director of Nursing

Police Academy Department
Director of Nursing

Infection Control Directorate
Director of Nursing

School Health Department
Director of Nursing

Dental Department
Director of Nursing

Central Prison Department
Director of Nursing

Quality and Accreditation Directorate
Director of Nursing

Blood Bank Department
Director of Nursing

Structure in all Primary Health Centers
Assistant Director of Nursing
Clinical Instructor
Head Nurse
Staff Nurse
Assistant

Structure in Hospitals and Central Department
Assistant Director of Nursing Staff Development Unit
Assistant Director of Nursing Management
Clinical Instructors
Head Nurses
Staff Nurse
Assistant

Figure 2.16: Organisational Structure of Nursing Department (Nursing Departments Organisation Structure, 2020, as adopted from Nursing Directorate/ Kuwait 2020)

2.11. Workforce Planning

Kuhlmann (2006) highlighted that welfare and social status helped to enhance professional status. Further, Galazaka, Brooke and Spencer-Veale (2020) stressed that the status of nursing could be improved by evolving the knowledge and practice of nursing so they can be able to diagnose, identify and differentiate between healing or not healing wounds, which can assist in improving the decision related to the patient's condition. However, there is no effective investment in nursing programmes in Kuwait. Also, the majority of the nurses are non-Kuwaiti nationals so when the government is investing in training those nurses tend to leave for other countries after acquiring training and knowledge, especially after the pandemic of COVID-19. According to Bayliss-Pratt, Daley and Bhattacharya-Craven (2020), nine million nurses and midwifery positions remained vacant. Therefore, workforce planning in Kuwait focuses on recruiting nurses to overcome the staff shortage rather than improving the quality of the nurses' services through developing new nursing specialities.

2.11.1. Workforce Planning and Religion

The nursing profession is influenced by several factors such as cultural background, socioeconomic and other factors such as religion. Lovering (2008) acknowledged that religion contributes significantly to reforming society's perception of the nursing profession. As a religious recommendation, nuns from the Christian church were serving patients before developing the profession of nursing in the Western countries, similarly, in the Muslim countries, females were serving the victims during the war. The main example was Rufaida bint Saad Al-Aslameya, who is considered the first nurse in Islam and participated in the war during the Prophet period (El. Hadad, 2006; Al-Asmar, 2023). This proves that the female in Islam was highly recognised and involved effectively in treating the people during Wars. Also, in the United Kingdom, the spiritual framework assists Florence Nightingale in developing the nursing profession (Atkinson, 2015). In this regard, religion is known as the participation of people with similar faiths, beliefs, and practices (Chatters, 2000; Kaye and Raghavan, 2002). It is a vital feature in Kuwait, Qatar, Jordan, and Egypt; that cannot be compromised; however, Kuwait and Qatar are more conservative countries as mentioned in Chapter 1, and the citizens are mainly Muslims. This helped to shape the constitution and policies following the teaching of Islam. In order to provide personalised care, the Ministry of Health in Kuwait and Qatar aim to distribute nurses in different departments based on their spiritual beliefs. For example, matching similar religions between patients and nurses as much as possible to understand patients spiritually and emotionally to enhance the quality of the health services and understand

patient needs. Also, religion is helping in evolving community perceptions and practices. Kuwait, Qatar, Jordan, and Egypt as Muslim countries give more consideration to religion in daily activities which is reflected in the costumes and traditions as shown in Figure 2.17, further, it is transferred to the norms and principles. For example, in the religion of Islam, the male is not allowed to provide healthcare to females unless a life-saving situation occurs and this has to be written in the policy and guidelines (Abukhadeejahrab, 2023). The religious aspect is already considered in the policies in Kuwait, Qatar, Jordan, and Egypt, when assigning nurses among departments for example, a Muslim female is required to receive care from a female nurse only, due to religious restrictions. Therefore, only female nurses are allowed to work in female departments. Based on female preferences sometimes female nurses work in male wards to overcome the shortage of male nurses, with some limitations to basic nursing care like checking vital signs, monitoring intake and output, giving oral and intravenous medication, further, performing paperwork like staying in the nursing station (counter) and preparing for doctors' rounds.

Both Religion and culture helped in designing the healthcare system in Kuwait and Qatar (Atkinson, 2015) as well as Egypt and Jordan. Accordingly, male and female departments are separated in the hospitals. In line with the policy and guidelines, it is necessary to consider religious restrictions along with the provision of services. For example, in order to develop TVNs, it is important to provide sufficient specialised male and female nurses to provide wound management for both genders. Apart from that Muslim female customs are not functional for the designated job such as cleaning a wound or applying a dressing, as shown in Figure 2.17. This illustrates the importance of religion in shaping the nursing profession in Kuwait, Qatar, Jordan and Egypt and it is important to consider the religious consideration in order to develop TVNs.

Figure 2.17: Gulf countries National Customs (Stølsvik, 2015)

2.11.2. Workforce Planning and Gender

Gender inequalities can also impact workforce planning for nursing. For example, if the nursing profession is seen as a "women's profession" this can lead to a lack of investment in workforce planning and training, as well as a lack of recognition for the important work that nurses do. This eventually, can lead to nurses shortage in certain areas, particularly in specialties that are perceived as being "male-dominated," such as emergency department, operation theatre and critical care. On the other hand, males are demotivated to enter a female-dominated occupation such as nursing (Williams, 1992). Nursing Times (2008) highlighted that men are a minority in the nursing profession. Also, some believe that the nursing profession is linked to being feminine. Gender differences and community perceptions negatively affect the nursing profession as mentioned in (Section: 2.3.3.1, pages: 43-44). The issue of the nursing profession is related to being feminine and gender configurations. Considering the role of the female in society is mainly linked to having a family and raising children which can interfere with the nurse's duties such as having night duties or working with a male worker (Tlaiss, 2013). According to Shockley et al. (2017), 41% of females preferred flexible work where they can work fewer hours so they can care for their families. In the same perspective, Mwachaka and Mbugua (2010) and Alawad et al. (2015) stated that married females prefer a suitable job for their social conditions such as morning duties where they can manage between caring for family and going to work. This implies that females prefer a job that allows them to balance between career and family needs. This possibly explains why in history nursing career is associated with females.

Nevertheless, in Gulf countries, such as Kuwait and Qatar, nursing has low professional status, with both males and females seeking professions other than nursing. Men are considered the minority, for example: in the United States, they cover 10% only of the total number of nurses (Landivar, 2013), and female nurses cover 90%. Certainly, this issue is not only linked to the Middle East or Gulf countries, but a similar issue exists in Western countries. A study conducted by Salter (2007) highlighted that in the case of an obstetric gynaecological department, 67% of the female students reported having convenience in working in the department based on gender-centred factors. In contrast, 42% of male students reported that they preferred to avoid working in obstetrics and gynaecology, because of negative comments from other friends and patients' unacceptance (*ibid*). Since females are dominant in the nursing profession, this leads other females to enrol in nursing and hence nursing becomes a common career for them. Still, Christensen and Knight (2014) underlined that nursing is the best career

that can be applied for both genders. For example, males and females have an option to select different nursing specialities based on their preferences. Male nurses find the nursing profession more attractive because they can work in different areas such as the emergency department or operation theatre which can be more suitable for male nature along with high wages (Mwachaka and Mbugua, 2010; Alawad et al., 2015). Considering these issues is important to attract gender in the wound nursing speciality.

2.11.3. Workforce Planning and Diversity

Diversity is as important as religion, it is considered a fundamental part of the health workforce. It helps to expand the services by creating a culturally competent workforce, through providing access to high-quality health services (Cohen, Gabriel and Terrell, 2002). This will include considering demographic factors such as habits, migration patterns, gender, and age. Diversity focuses on the background or the ethnic group of individuals, it also helps in effective staff distribution or human resources management, which will assist in the maximum utilisation of the staff. The M.O.H. in Kuwait focuses on recruiting nurses from India as it is more economical compared to other countries. Assigning different nurses' staff from different nationalities or backgrounds will help to provide a high standard of healthcare because each nationality has its own skills which will improve staff performance. On the other hand, health workforce planning focuses more on the staff capability and quality rather than the staff number, in meeting the current challenges that are associated with the frequently changing demands (Drennan and Ross, 2019). Both workforce planning and diversity aim to improve the services. This implies that diversity is linked with workforce planning. Diversity could help to improve the policy and workforce planning in accordance with the new requirements. This in return, assists in shaping the position in the nursing profession. For example, to train the nurses for the new nursing speciality /TVNs, Kuwait, Qatar, Jordan, and Egypt; should obtain assistance from foreign countries, to get specialised nurses who are already familiar with skin and wound management such as Tissue Viability Nurses.

2.11.4. Workforce Planning and Culture

The provision of adequate ethnic diversity could have a positive effect on healthcare services. Despite that, in Kuwait and Qatar, this could be disadvantageous because of the language and cultural differences, which might cause a gap in communication between nurses and patients. For example, the majority of nurses are from foreign countries especially India, so this could result in miscommunication, especially with the elderly who mainly know the

Arabic language. In this context, Aldossary, While and Barriball (2008) stated that the provision of effective and efficient nursing care is highly associated with shared language and culture. This means that Kuwaiti and Qatari society is highly associated with their tradition and culture. Additionally, the vast majority of nurses in the community healthcare services are Kuwaiti nationals or Arabs to help communicate in the Arabic language with the clients. Contrariwise, non-speaking Arabic are assigned to departments that require less verbal communication with patients such as the Operation Theatre or Intensive Care Units keeping into consideration staff experience and skills. In regard to Jordan and Egypt, both countries are recruiting national nurses and they do not have major issues related to nurses' shortage or immigrant nurses as in Kuwait and Qatar. Indeed, cultural differences could cause some confusion for nurses. As an example, some cultures follow specific dress codes which are not acceptable in the Kuwaiti and Qatari cultures. In addition, nurses' uniforms must be long and appropriately cover the body, which might create hurdles while cleaning wounds and dressing. The dress code of nurses in Kuwait is given in Figure 2.18 below.

Figure 2.18: Nursing Uniform in Kuwait (PTI, 2015)

Creating a new nursing speciality could be supported or rejected by society, this is depending on the community's perception and understanding of the role and responsibilities of the new nursing speciality. In addition, based on Galazka (2021) dealing with chronic wounds and cleaning infected wounds is considered an unpleasant job because it requires handling and removing pus and bodily fluids. Therefore, understanding the culture in Kuwait, Qatar, Jordan,

and Egypt is important in order to develop TVNs. According to Brunner and Kada (2010) and Oberhuemer (2015), cultural differences and social perceptions play a significant role in developing a new profession. Since social perception is necessary to understand the professional role, then, professional knowledge and action depend on the cultural framework. Moreover, Brunner and Kada (2010) asserted that cultural and educational differences cause prominent challenges between countries. For example, in GCC male nurses are not accepted to work in the labour room or paediatric department (Attum et al., 2018). This makes male nurses limited to certain practices due to community perceptions and cultural aspects. Also, the nurse's curriculum in Kuwait differs from the nurse's curriculum in India, so when Indian nurses arrive in Kuwait, they need to be trained again for a certain period. This increases the burden for other nurses.

2.12. Summary

The professionalisation of nurses refers to the process of developing and advancing the profession through education, training, and standards of practice, which assists nurses in becoming more systematic and recognised with defined roles. It has a direct impact on improving nurse's role in wound management. Further, it equips nurses to use their unique knowledge to improve patient outcomes and provide high-quality care. This allows nurses to gain a deeper understanding of skin integrity, skin care, wound management and improving the healing process. The professionalisation of nurses could strengthen nurse's role in wound management and skincare leading to greater recognition of the importance of specialised knowledge and skills in wound management and improved wound management. However, there are several organisational, cultural, and social factors and powers that impact the development of the nursing profession.

CHAPTER THREE

METHODS AND METHODOLOGY

3.0. Introduction

The narrative literature review related to the research topic provides a clear focus for the research and helps to identify the impact of policy, organisational and contextual factors in developing TVNs in Kuwait, Qatar, Jordan, and Egypt. Additionally, to develop a comprehensive understanding of the state of knowledge related to the research questions and objectives, this chapter discusses the methodological approach and the adopted methods along with the rationale and reasoning for selecting the research design and method. Consideration was given to the data collection process, ethical aspects, and analysis, further to this, data protection and management issues are highlighted. A qualitative approach was adopted to provide a deeper understanding of individual behaviour towards the nursing profession and further explore the social relationships between nurses and doctors related to their professional roles, along with cultural and organisational factors that impact the nursing profession. This comprehensive data helps to achieve the research aim and answers the research questions.

3.1. Developing the Research Methodology

This chapter focuses on the methodological approach, research design and methods that are aligned with the research aim and objectives. The research method is the applied tool used for data collection (Finn, Walton and Elliott-White, 2000; Walliman, 2011). Bryman and Bell (2011) and Mishra and Alok (2022) stated that the research method assists the researcher in having an understanding of the unfolded aspect of the research area. Consideration needs to be given to selecting adequate research methods in order to ensure the achievement of the research objectives (Sekaran and Bougie, 2016). It also supports the existing literature so that a basis can be provided for future research on the topic under consideration. On the other hand, the research methodology is the adopted scientific approach to conduct the research, like the philosophical approach and research process, which includes data collection, analysis, and interpretation. It is a systematic approach that helps with investigating the research issue and

achieving research objectives (Kothari, 2004). Hence, this chapter helps to achieve these objectives, and answer research questions as follows:

3.1.1. Research Objectives

1. To understand the influences of developing specialist nurses in tissue viability in Kuwait, Qatar, Jordan, and Egypt.
2. To explore the challenges of the development of specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt.
3. To discuss the feasibility of developing specialist nurses in tissue viability from different perspectives, through the decision makers (policymakers in the Ministry of Health, hospital directors and director of the nursing directorate) and gatekeepers (general/specialised nurses, nurses-team leaders, head nurses, nursing assistant director, nursing director and doctors).
4. To provide recommendations on how tissue viability nurses, as specialist nurses are feasible in Kuwait, Qatar, Jordan, and Egypt.

3.1.2. Research Questions

1. What are the contextual factors that affect the development of speciality nursing in tissue viability in Kuwait, Qatar, Jordan, and Egypt?
2. What are the barriers and facilitators to developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt?
3. Is the professionalisation of nursing an opportunity for developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt?

The researcher's experience is shaped by collecting and analysing the data. For example, the research strategy and plan are amended according to the changes in research questions and aims. A particular process of data analysis is applied to enhance the quality and richness of the knowledge, as will be explained later in this research. The reflectivity and ongoing analysis of the data are used in an iterative way that reflects what is emerging and therefore influences the research tools. It is important to know how things really work, what individuals know about nursing specialities and what factors influence the nursing profession. Then, generating different themes to provide more understanding. This research adopts the 'Research Onion' as shown in Figure 3.1, which helps to develop an in-depth understanding of

the issue through a systematic approach (Saunders, et al, 2007). This research onion is applied intensively in the research to facilitate the researcher's decision-making.

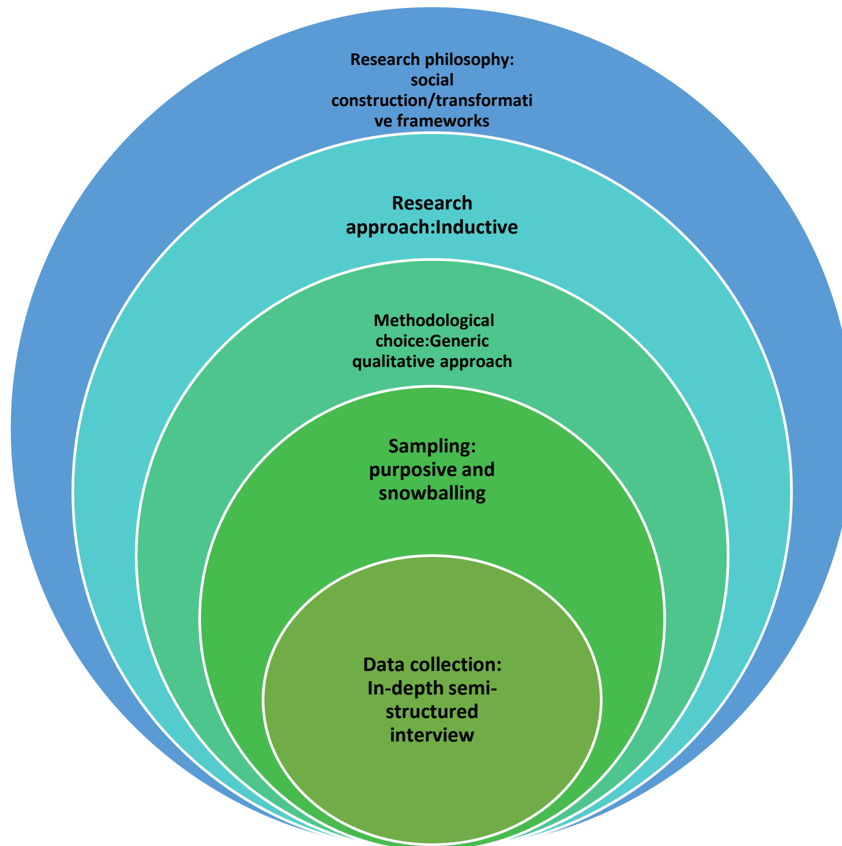


Figure 3.1: Research Onion Model, Adapted from Saunders et al. (2007)

3.2. Philosophical Assumptions

Philosophy is simply identified as the application of abstract ideas or beliefs in research, and it develops from existing knowledge and experience. The philosophical assumption refers to the first idea that is generated to establish this study. In philosophy, the researcher develops an understanding based on knowledge, beliefs, and interpretation of the facts (Yanow, 2015). Sometimes the researcher's beliefs and philosophical assumptions are deeply rooted which is reflected in the researcher's views and approach. The researcher's beliefs are integrated into the scholarly communities in which the researcher engages in

conferences or meetings and educational training from the university or part of the organisation's training. As a researcher, it is important to differentiate between reality and theory, by avoiding twisting the reality and facts or manipulating the words to make it look interesting. Sometimes, the findings are unexpected which puts the researcher in a dilemma of whether to present the reality or try to twist the word. Moreover, the way of presenting the fact holds significance especially when supporting it with evidence from a previous research paper. The researcher's view must be generated and presented from reality, for example, a situation or recent experience; it must be presented the way it is in order to solve the issue or correct it. Yanow and Schwartz-Shea (2015) argued that research philosophy reflects the researcher's most basic presuppositions. In some qualitative studies, philosophy is made ambiguous, only a discerning reader can render the subject to different themes. There are a variety of theoretical and interpretive frameworks that reflect the researcher's assumptions and beliefs, further, it gives the rationales for the applied methodological approaches.

Selecting relevant philosophy is essential to understanding human knowledge, fact, and truth, it also helps in analysing the nature of events logically. The basic perception of philosophy comes from developing a scientific explanation to a basic perception such as an old theory, wisdom, or fact. Therefore, the foundation of the philosophy could be changed depending on the emerging dimensions and views related to the social world (Uddin and Hamiduzzaman, 2009). The philosophical direction and research design are essential to help in gathering accurate data. Further, it is considered evaluative criteria to make appropriate research decisions and to differentiate between an appropriate and inappropriate plan (Huff, 2009; Welch and Piekkari, 2017). However, it can be challenging for the researcher to ascertain the philosophical assumption that is applicable to the research, these assumptions can be changed depending on the research aim and needs. In this context, there are four philosophical assumptions or paradigms that are used to guide the researcher while undertaking a qualitative study (Guba and Lincoln, 1988; Denzin and Lincoln, 2011), it is commonly applied within social sciences research. These beliefs and philosophical assumptions are presented in Table 3.1.

Table 3.1: Philosophical Assumptions with Implications for Practice

Assumption	Description
Ontological	- The nature of reality is investigated.
Epistemological	- Investigate the knowledge, whether it is justified or not. - Assess and evaluate the relationship between the researcher and what has been researched. - The references and quotes will be the main sources of evidence for the researcher to rely on. - Knowledge is explored through an individual's experiences in the working field
Axiological	- The importance of values in shaping the narrative and interpreting accordingly. - The researcher's values and biases will be well-known from the gathered data. - Develop "positionality" according to social positions like age, race, gender, personal experiences and professional and political beliefs
Methodological	- The procedures of qualitative research.

Adopted from (Wolcott, 2008; Berger, 2015)

3.2.1. Epistemology and Ontology

Epistemology and ontology are two vital concepts in qualitative research that relate to how researchers understand and approach the nature of reality and the acquisition of knowledge. Epistemology is the study of knowledge and the process of acquiring it (Cresswell, and Poth, 2018). In qualitative research, epistemology concerns how researchers gain knowledge about the social world, individuals, groups, or phenomena (*ibid*). Researchers have different epistemological perspectives, which can affect their choice of research methods and data analysis techniques. For example, some researchers might view knowledge as subjective and contextual, while others might see it as objective based on empirical evidence. On the other hand, ontology refers to the study of the nature of existence or reality and to describe

knowledge (Cresswell and Poth, 2018). In ontological assumption, the researcher represents different perspectives of realities in themes by using the actual words of people as evidence (Bravo, Reyes and Ortiz, 2019). For example, sharing individuals' experiences while participating in a study (Moustakas, 1994). In qualitative research, ontology concerns the researcher's beliefs and assumptions about the nature of the social world and the individuals and the issue (Ormston et al., 2014). Researchers might have different ontological perspectives, which can influence their research design and methods. For example, some researchers might view the social world as subjective and constructed through social interaction. Therefore, it is important to know how things really work in real life; what individuals know about nursing specialities and what factors influence the development of the nursing profession. Then, generating different themes according to the participant's answers. Saunders et al. (2015) stated this philosophical assumption has two perceptions related to reality "subjectivism" and "objectivism".

Subjectivism is a philosophical position that includes the process of individuals' determination to understand realities (Moon and Blackman, 2014). This reality is socially constructed through the subjective experiences, perspectives, and interpretations of individuals. In research, subjectivism could have implications in the way that research is designed and conducted. Subjectivism suggests that reality is shaped by individual experiences and interpretations, hence, it might be difficult to generalise findings to other contexts or populations (Ragab and Arisha, 2018). It emphasises the importance of individual experiences and interpretations in shaping the nature of reality. This perspective provides an important insight into social phenomena, it also illustrates the challenges that are associated with establishing the objectivity and generalisability of research findings (Sinkovics, Penz and Ghauri, 2008; Bahari, 2010). On the other hand, when reality exists independently based on individuals' personal experiences and interpretations this is identified as objectivism (Hamati-Ataya, 2014). Objectivism is another category in the philosophical position; here the nature of reality can be explored through objective or empirical methods of inquiry, rather than forming reality based on individual perspectives. This philosophical position serves numerical data in the quantitative study; mostly this type is adopted to observe and measure different phenomena that require personal experiences and interpretations (Hiller, 2016; Ataro, 2020). This type emphasises the importance of standardisation and the use of reliable and valid measures in order to establish the objectivity of their findings. Consequently, this perception can offer important advantages in terms of the generalisability and objectivity of research findings.

However, objectivism can present challenges in terms of the complexity and contextual nature of social phenomena which are shaped by individual experiences and interpretations (Creswell and Poth, 2018). Additionally, the use of standardised measures might fail to capture the full complexity of social phenomena, leading to a lack of nuance in research findings (*ibid*). The choice of research paradigm depends on the research question and the nature of the phenomena under investigation. Therefore, in this research, a subjectivist approach is used, which emphasises the importance of subjective experiences, interpretations and developing meaning.

Overall, both ontology and epistemology are interconnected and important to consider widening and shaping the researcher's understanding of the social world and influencing the research methods and data analysis techniques. Tuli (2010) asserted that philosophical concepts are interlinked and also provide a justification for methodology and methods throughout the research approach. Therefore, this research adopted the ontological path of subjectivism, to enhance the understanding and interpretation of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. This includes giving clarity and facilitating the interpretation process by understanding the practice and role of the nurse and how this could influence nurses' role in improving skin integrity and wound management. Understanding reality will be developed from individual experiences and interactions through daily life activities such as the interaction between nurses and doctors related to wound management. Thus, would assist in constructing realities based on the exposure to the cultural, organisational, and contextual factors that impact nurses' practice, experiences, views, and behaviour.

3.3. Interpretive Frameworks

Denzin and Lincoln (2011) believed that selecting the relevant philosophical assumptions is the key premise for interpretive frameworks. Each interpretive framework has given particular terms that make it easier for the researcher and readers to understand. It could be individual beliefs, theories or theoretical orientations that direct the researcher and shape the research process. For example, leadership theories, attribution, political influence and control, all these social science theories are used to develop a strong theoretical lens in studies. The interpretive frameworks are expanding significantly in social science to present justice or any remarkable change in a society like improving people's perceptions about the nursing profession. Likewise, Ritchie et al. (2013) highlighted the importance of interpretive frameworks to the issues that are associated with social justice and general human rights concepts. Therefore, this paper focuses on certain frameworks as given in Table 3.2.

Table 3.2: Interpretive Frameworks in Qualitative Research

Postpositivism	Postpositivism is related to the engagement of individual beliefs in the qualitative study (Creswell and Poth, 2018). It is a scientific approach that employs a social science theoretical lens to identify the probability of all causes and effects that may occur in the research (Nickerson, 2022). It has different dimensions: cause-and-effect oriented, logical, reductionistic, empirical and deterministic.
Postmodern Perspectives	It is focused mainly on changing the ways of thinking for the first instance. This framework is believed to be a family of theories, where the knowledge is developed based on the world's recent conditions in regard to race, gender, class, and other group affiliations (Slife and Williams, 1995). These conditions are easily notable in the hierarchies and individuals' power, control, and language. It is significant for marginalising people and initiating different debates regardless of the social conditions (Cresswell and Poth, 2018).
Pragmatism	It could be found in different forms, such as in individuals' actions, situations, outcomes, and the consequences of the study all seeking rationality. However, the researchers could get confused related to "what could be work or what would be the solutions for the issue" (Patton, 1990 as cited from Creswell and Poth (2018: 64). Also, Rossman and Wilson (1985) argued that this approach gives less consideration to the research methods. It is believed that pragmatism needs to think of an alternative to reality and laws of nature questions (Cherryholmes, 1992). Morgan (2014) highlighted that it enables the researcher to decide the research methods, or techniques freely based on the needs of the research. It could take place in social, political, historical and some other contexts.
Social Constructivism	It assists researchers in understanding the surrounding world, where they live, and work and it is mainly concerned with knowledge and reality

	(Denzin and Lincoln, 2011). The researcher's personal meanings and interpretations developed based on their experiences. Socially and historically those meanings are exchanged, through individuals' interaction with others, for example, through culture exchange which reforms the daily norms (Cresswell and Poth, 2016).
Transformative Frameworks	It fits into the research when the theories are not applicable or not sufficient to provide support for individuals (Atweh, Kemmis and Wilkinson, 1998). It facilitates individuals' progress and eliminates their fear of media or power in their work settings by enabling participants' voices to be heard. It gives more attention to society's problems like the need for empowerment. It also helps with developing agendas and designing the research questions, data collection and analysis (Cresswell and Poth, 2018).

3.3.1. Social Constructivism

According to Keaton and Bodie (2011), interview questions have to be general with a wider meaning which allows the participants to construct the meaning based on the situation. For example, an interview question about the effect of COVID-19 on working practices can allow the interviewee to express the respective experience leading to the development of social construct. This helps to expand the researcher's view and focus on the complexity of their views instead of limiting the meanings to a few ideas. The meaning itself is formed during the discussion and interactions between the participant and researcher. Therefore, constructing semi-structured questions would enable the researcher to understand the historical and cultural backgrounds while listening carefully to the responses (McIntosh and Morse, 2015). Consequently, the researcher's position could emerge from their personal experience and historical and cultural exposure (Creswell and Poth, 2016; Creswell and Poth, 2018). In addition, it is important for the researchers to acknowledge their position along with the participants and use this position to facilitate the research process to generate new knowledge. For example, if the researcher has a certain social standing such as a decision-maker where certain decisions can be taken to solve the issues. Understanding the context of the research is essential for the researcher to focus on the subjectivity of their own interpretive lens, which

could call for necessitating action such as policy development or developing TVNs. The researcher looks at different aspects of the research as given in Figure 3.2, it tends to explore and understand the realities, through people's meaning and interpretation of their thoughts regarding social phenomena related to the nursing profession. For example, verbal or physical violence toward nurses. It also looks at the social and cultural norms that constructed and shaped the nursing profession. For example, using interviews to obtain more knowledge from interviewees through constructing relevant research questions to understand the reality of nurses' role related to wound management. By applying social interpretation, the researcher can focus on the language and look deeper into nurses' social interactions and experiences to understand their social, historical, and cultural practices (Van Dijk, 1997; Jung, 2019). Therefore, the discussion and interaction through using semi-structured in-depth interviews can allow the researcher to construct the meaning related to nursing issues such as the lack of nursing specialities in Kuwait, Qatar, Jordan, and Egypt. These issues can be associated with the cultural norms and society perception which can only be explored from the participant's responses. Also, the perception of the nursing profession as a semi-profession (Chapter Two, Section 2.8, pages: 64), is a concept generated from the society and culture and developed in individual minds. The role of social constructivism in this regard is that it helps in exploring the social forces surrounding a social phenomenon, these forces tend to occur in the form of behaviour and response. The response or behaviour towards nursing can undermine the profession hence its development. Therefore, adopting this framework can contribute to understanding the origin of these actions and behaviours through the data collection and analysis process. Therefore, applying in-depth interviews allowed the researcher to get more information from the nurses and the key informants to provide an understanding of these actions and how they contribute to the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt.

Figure 3.2: Different Aspects of Research

3.3.2. Transformative Frameworks

A transformative framework is an alternative that could be used by the researcher. Caraballo et al. (2017) described a transformative framework as a participatory action that is recursive and aimed at making changes in practices. However, not all individuals are excited about the change. There is a high chance those participants might face some challenges related to domination, oppression, suppression, hegemony, and alienation (Creswell and Poth, 2018). Those challenges could appear because the issues are exposed by the researchers to raise individual consciousness and provide a voice for those individuals to improve their lives (Johnson, 2022). It is perfectly designed to fit with the areas of social science that consider oppression, domination, and inequity (Gray and Coates, 2018). The outcome of this is to deliver the participant's voice and make it heard throughout the research process.

Knowledge reflects individual power and social relationships within society; it facilitates individuals to improve society, besides, it represents a basic assumption related to this transformative framework. According to Mertens (2017), building a strong base of knowledge helps to improve society, by applying this knowledge for individual improvement. Knowledge must develop plans and agendas to enhance the possibility of change for a better life and work circumstances. Therefore, this framework used knowledge to empower nurses to integrate into society as an essential profession. The optimal use of nurses' knowledge will assist the development of theories to support the nursing profession. This will include developing nurses' practice in the area of wound management and skin integrity in Kuwait, Qatar, Jordan, and Egypt. Adopting this framework will enable changing roles and performance in regard to decision-making, particularly in the area of skin integrity and wound management. In addition, understanding the challenges that nurses are facing such as a lack of a career structure that is not supportive of the development of the nursing profession which is the main hurdle for nurses' professional development and progress. Besides, there are other factors like organisational challenges that can be identified by the nurses themselves. All these factors if addressed will transform nurses' professional roles and practice effectively. Therefore, the researcher uses the research process to identify the issue and search the literature to explore more about the phenomena as explored in chapter two. The process of qualitative research starts with identifying the issue and the applicable design and tools that fit the research to provide transformative ideas related to the nurse's roles and practice. For example, the researcher aims to answer the research question by using a theoretical lens that might guide in exploring the gap in nurses' knowledge related to wound management, it also helps in

understanding the reason of lack nursing specialisation in Kuwait, Qatar, Jordan, and Egypt. For instance, adopting certain transformative criteria to assess the research findings regarding addressing social issues such as power dynamics and gender inequalities and then applying the transformative frameworks to facilitate social change related to these issues (Sweetman, Badiee and Creswell, 2010). Therefore, the analysis and findings of these data would be used to provide information for policymakers to develop interventions, which might assist in advocating for a new nursing speciality in skin integrity. This implies that applying Transformative Frameworks would be valuable in this research.

Researchers use the interpretive framework to describe their views and beliefs, how this is related to the research problem and questions and how it can develop the analysis based on selecting appropriate methods for data collection. Therefore, a rich outcome will be generated following the interpretation, which might require actions that would be explicit after analysing the data. This study intends to explore the nursing profession in Kuwait, Qatar, Jordan, and Egypt, which involves exploring the enablers and barriers to developing the nursing profession. Substantial attention was given to cultural, organisational, and other contextual factors that influence the development of the nursing profession in the named countries. Adopting social constructivism and a transformative framework enhanced the researcher's understanding of the issue by exploring the social factors that impact the nursing profession such as behaviour interactions, values, and violence. Applying qualitative research helps the researcher to explore several philosophical assumptions and interpretive frameworks. Both interpretive frameworks and philosophical assumptions are linked together to strengthen the data from qualitative research. The following Table 3.3 shows the associated philosophical beliefs and interpretive frameworks according to Cresswell and Poth (2018).

Table 3.3: Philosophical Assumption and Interpretive Frameworks

Interpretive Frameworks	Ontological Beliefs (the nature of reality)	Epistemological Beliefs (how reality is known)	Axiological Beliefs (role of values)	Methodological Beliefs (approach to inquiry)
Social constructivism	Multiple realities are constructed through lived experiences and interactions with others.	Reality is co-constructed between the researcher and the researched and shaped by individual experiences.	Individual values are honoured and negotiated among individuals.	More of a literary style of writing is used. The use of an inductive method of emergent ideas (through consensus) is acquired through the following methods: observing, interviewing, and analysing texts.
Transformative	Participation between researcher and communities or individuals are involved in the study. Usually, reality emerges.	There are co-created findings with multiple ways of knowing,	- There is respect for indigenous values. - Values need to be problematised and interrogated.	Methods entail the use of collaborative processes in the research, questioning of methods, encouraging political participation, and further highlighting concerns.

Adopted from (Cresswell and Poth, 2018)

3.4. Methodological Approach and Data Types

The methodological approach helps in developing the analysis and enhancing the understanding of the issue related to the nursing status, further, it helps to identify the barriers and enablers to developing TVNs in Kuwait, Qatar, Jordan, and Egypt. The selection and application of the research methodology and the choice of methods were developed based on research needs. It was necessary to have more data to expand knowledge and to assist in understanding the issue in-depth in the named countries. The qualitative approach is designed to explore individuals' experiences and understand what individuals know about TVNs and

what they feel or think. This assumption keeps the researcher familiar with the issues related to the nursing profession. Also, in qualitative data, the view of the researcher and participant can be captured. The methodology succeeded in collecting high-quality data related to the research. This data assisted in developing an understanding of the absence of nursing specialisation by creating a solid foundation for the nursing profession in Kuwait, Qatar, Jordan, and Egypt. This research methodology is a significant tool to understand nursing roles, it can also shape the future of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. Three methodological approaches can be used to conduct research, they are quantitative methods, qualitative methods, and mixed methods approach, however, this research used qualitative methods for several reasons as will be explained in this chapter.

3.4.1. Qualitative Research Designs

When it comes to the actual implementation of qualitative research, both philosophical assumptions and interpretive frameworks are necessary to enhance the understanding of the issue. However, within those assumptions and frameworks, there are different approaches or designs. Qualitative research design is the process of producing the required knowledge to achieve the research objectives. It also highlights the research questions and enhances the understanding of social science theories (Tobi and Kampen, 2018). Therefore, it guides the researcher in selecting appropriate methods and strategies of inquiry. It is commonly used to investigate cultural aspects, natural inquiry, constructivist paradigm, and phenomenological investigation (Schwandt, 2001). Selecting the relevant research nature could be influenced by the existing literature related to the research and to the extent that the topic has already been explored (*ibid*). Research can be of three different distinctive types such as descriptive, explanatory, and exploratory (Cresswell and Clark, 2011).

3.4.1.1.Descriptive Research

Descriptive research is applied to provide a detailed description and measurement of the characteristics of the current issue, without establishing relationships between those variables (Koh et al., 2000). It helps the researcher to provide a detailed image of the issue. Therefore, it helps to establish a basic understanding of the issue. It is commonly used in social sciences and public health research. Quantitative researchers prefer applying this type of research to generate hypotheses that can be experienced in future research. It focuses on applying large sample size and standardised data collection methods. This type can be used as an important tool in identifying different patterns and trends in a population.

3.4.1.2. Explanatory Research

Identifying the causal relationship between variables in the research is known as explanatory research (Sainani, 2014). This type helps to explain why a particular issue occurs, along with testing the hypotheses related to the relationships between different variables. It is often used to support or disprove theoretical explanations of phenomena and it helps to identify and control the occurrence of any phenomenon. It involves the use of experiments in which one or more variables are manipulated to observe their effect on the outcome variable (Apuke, 2017). Data collected in explanatory research is often quantitative meaning, that it is focused on collecting numerical data that can be analysed statistically to identify patterns and relationships between variables. It is often used in fields such as psychology, economics, and sociology, where researchers seek to understand the causal mechanisms underlying social behaviour and economic phenomena. It can be an important tool for establishing cause-and-effect relationships and for testing the validity of theoretical models of social or economic phenomena.

3.4.1.3. Exploratory Research

Exploratory research is a type of research that is conducted in the initial stages of a study when the research problem or question is not yet well-defined. It is a flexible and iterative approach as it aims to generate ideas and insights into a phenomenon and to develop an initial understanding of the topic being studied (Creswell and Poth, 2018). Exploratory research is often applied in qualitative research when the researcher is not certain about the applicable research approach for the study, further, in the existence of the limitation of the research topic. It is commonly used in social sciences, and it helps to clarify the research question as well as identify the potential variables that used to be measured before the end of the research (Stebbins, 2001). Therefore, this research developed the interview questions in order to achieve the research aim and answer research questions. For example, the issues related nursing profession can be explored by nurses only, however considering the role of other participants (doctors, nurses, and directors) is significant to serve the research purpose and explore the issues from different angles. Also, exploring the challenges of the development of specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt can be achieved through the actual implementation of the research and data collection process. Therefore, this research adopts an exploratory approach to gain insights and enhance the understanding of the issues related to individual behaviour and experiences in dealing with skin problems and wounds.

Further, understanding the reason for the absence of TVNs in Kuwait, Qatar, Jordan, and Egypt. Additionally, it explores the barriers or facilitators of developing TVNs.

3.4.2. Qualitative Approach

The qualitative approach emphasises on the experiences that occur in natural settings in the real world, it includes exploring those experiences with their difficulties (Leedy and Ormrod, 2010). Qualitative research tends to use words such as explore and narrate rather than answers which implies a finite conclusion, further explaining the issue to understand reality. Ellis and Hart (2023) highlighted that understanding the complexity and richness of human behaviour is the core of qualitative research. Besides, the outcome of health models and social theories could be developed in qualitative research because it focuses on human behaviour and social interaction (Willis et al., 2007). For example, the interaction between doctors and nurses related to patient care, including wound care and management. According to Blandford (2013) and Moriarty (2011), in the socioecological model applying a qualitative approach intended to generate vigorous evidence related to the issue, by exploring the issue from a different angle, for instance, the social relationships and the professional role between nurses and doctors. This implies that qualitative methods are best applied in social science. Likewise, a qualitative approach has its own measures of trustworthiness and integrity by assessing and reviewing the accuracy of research findings (Creswell and Poth, 2018). That can be checked by selecting the relevant participants, who have a role in the investigated area for instance the participants in this research are doctors and nurses who have clinical experience in managing wounds.

The qualitative research also focuses more on investigating why and how the decision has been made rather than where, when, and what. It usually answers questions related to the realities and personal experiences, to generate rich data which helps in understanding individual experiences. Consequently, qualitative research procedures are characterised as deductive, iterative, and inductive approaches (Kekeya, 2016). The inductive approach aims to develop a new theory regarding an existing issue, it focuses on specific observations to broad generalisations (Gioia, Corley, and Hamilton, 2013). Further, it has an interpretive nature that helps to answer (what, how, and why research questions), hence, providing a detailed understanding of the research subject and context (Blaikie, 2010). According to Scotland (2012), the application of the research process includes inductive logic to work within the context of the research. Therefore, the inductive approach is applied to provide an in-depth understanding of individuals' meanings, beliefs, and their impacts on the nursing profession in

Kuwait, Qatar, Jordan, and Egypt. Additionally, the qualitative research designs include several types such as ethnography, phenomenology, grounded theory, narrative, and generic; however, this research adopted a generic qualitative approach because it facilitates understanding the reality and answering the research questions as explained next.

The literature review provides information related to the development of the nursing profession along with the background of the profession. This background contributes to developing some understanding of the role of TVNs and the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. Therefore, the generic qualitative design is known as a basic qualitative, it is robust literature and is used to explore an individual's actual experiences within a real-world context (Kahlke, 2014), which assists in understanding and increasing knowledge by interpretation of personal meaning using interviews (Creswell and Poth, 2018). Applying generic qualitative design focuses on the presentation of several ideas and facts related to individual experiences and daily acts in the real world, it is also highly recommended for social sciences studies (Ellis and Hart, 2023). Despite that, Kahlke (2014) asserted that there is insufficient literature that discusses generic qualitative design. Both, Kahlke (2014) and Ellis and Hart (2023), highlighted that the generic qualitative design can be convenient when there are limitations in acquiring data; and if research questions are more exploratory in nature with a small sample size. For example, the previous chapter identifies there is limited and a lack of access to the nursing profession data in Kuwait.

Therefore, adopting a generic qualitative approach helps to achieve the research aim by exploring individuals' real-world experiences, behaviours, and roles related to wound management in respected countries. As well as identifying the challenges of the development of specialist nurses in tissue viability in Kuwait, Qatar, Jordan, and Egypt. Further, facilitates understanding of the lack of specialisation in the nursing profession. Additionally, explores decision makers and gatekeeper perspectives and behaviour toward nursing professionalisation which leads to understanding the reality by capturing their responses through talking and observing body gestures and interpreting them. It also helps the researcher to use experiences and reflect upon the challenges. This provides a deeper understanding relating to the policy, cultural, and organisational factors that impact nursing professionalisation. Besides, it widens the reader's understanding of the situation. For example, applying qualitative methods such as in-depth semi-structured interviews, can facilitate the participants to share their own experiences and understand the reality of their professional roles which cannot be obtained

with other research methods. Then, the reader can be familiar with the perspective of the nursing profession from the gatekeepers in the represented countries. The outcome of these interviews will contribute to providing an in-depth understanding of the issue and draw conclusions based on the participants' perspectives as will be explained later in this chapter.

3.5. Sampling

A successful qualitative method requires proper planning for sampling and recruiting. Sampling is known as a technique of studying the target population, by accessing a segment of the population (Raykov, 2000). The target population can be called participants, and it is selected based on the researcher's assumptions and judgments for providing the relevant information (Etikan and Bala, 2017). Therefore, the target population in this research are decision makers (a representative from the Ministry of Health/M.O.H.) and gatekeepers (nurses and doctors) at different hierarchical levels as shown in Figure 3.3. Probability and non-probability are two common sampling approaches for social science. Qualitative study can be served by non-probability sampling, which is divided into purposive, convenience and snowballing sampling. Qualitative studies focus more on the richness and quality of data, the sample size is usually manageable and smaller than those studies for quantitative purposes (Vasileiou et al., 2018). Kerr et al. (2010); and Carlsen and Glenton (2011) argued that qualitative research lacks justification and transparency in how sample sizes are selected. Despite that, Gill (2020); Guest, Namey and Chen (2020) highlighted that qualitative studies focus on the richness and depth of data based on the human experience. Therefore, sampling strategies in qualitative research are influenced by several factors that involve the research aim and objectives, research design and analytic approach, (Bryman, 2012; Malterud, Siersma and Guassora, 2016). Along with this, available resources such as location and timeframe, are relevant aspects for a productive data collection process. In this research, sampling has been done based on prevailing factors such as data accessibility, respondents' availability, an individual's interest and role as decision-makers or gatekeepers, timeframe as well as experience and other factors. Adopting purposeful sampling in qualitative research would provide a combination of logic and power in selecting the relevant participant to produce rich information related to the issue (Suri, 2011; Vasileiou, et al., 2018). It is used to enhance the consistency of the information, by identifying and recruiting the relevant key informants and decision-makers who have the knowledge and experience in the substantive domain of interest, as illustrated in Figure 3.3.

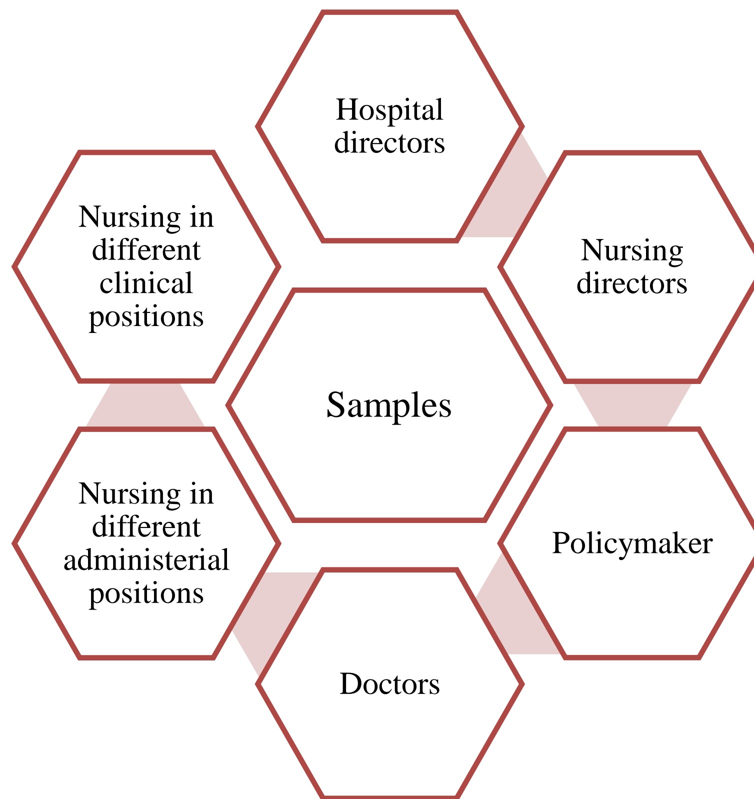


Figure 3.3: Target Population in this Research

3.5.1. Sampling Method

Purposeful sampling enables the researcher to focus on studying any convenient sample, whether in administrative or clinical positions. This can enable exploring individual perceptions about their role, duties and current practices in skin care and wound management. Accordingly, the target participants were health professionals (policymakers and key informants) as presented in Figure 3.3. This includes nurses in different hierarchical levels, like junior and senior nurses, and doctors. Both nurses and doctors tend to have experience in dealing with skin issues and wound management, they work in dermatology or surgical departments, from different health organisations in Kuwait, Qatar, Jordan, and Egypt. Apart from applying purposive sampling to determine the sample size, there were additional relevant aspects including the respondents' availability and timeframe, these are given in Table 3.4. Besides, snowball techniques were used with respondents to recruit further participants to

increase the richness of data. Snowball sampling helps in making explicit connections between the relevant participants in the research area. It is widely applied in qualitative research, particularly in social science. This type of sampling involves seeking further information and details from the decision-makers and gatekeepers to have clear thoughts about things that were not visible before (Naderifar, Goli and Ghaljaie, 2017). In this type of sampling, the information could be collected from the key informants, based on the stakeholder's recommendation. According to Noy (2008) and Suri (2011), snowball sampling allows the researcher to use a social circle in order to access the key informants through other informants. It is essential to expand the researcher's thoughts when other possibilities of accessing new participants have dried up. Consequently, identifying the key informants and the decision-makers was a little challenging. Hence, adopting the snowball sampling approach was very effective in connecting with further participants from Kuwait, Qatar, Jordan, and Egypt. The policymakers in Kuwait are used in directing to individuals who are meeting research criteria. In addition, this method helped in accessing the hidden population that was either not identified earlier or they were not accessible. The consideration of a relevant hidden population tends to influence the research outcome (Heckathorn, 2011).

Table 3.4: Research Timeframe

No	Task Name	Start Date	End Date	Quarter 4 2019			Quarter 1 2020			Quarter 2 2020			Quarter 3 2020			Quarter 4 2020			Quarter 1 2021			Quarter 2 2021			Quarter 3 2021			Quarter 4 2021			Quarter 1 2022			Quarter 2 2022			Quarter 3 2022			Quarter 4 2022			Quarter 1 2023			Quarter 2 2023			Quarter 3 2023		
				10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3	4	5	6	7	8	9
Stage 1																																																			
1	Project Approval	1/10/2019	08/05/2020																																																
Stage 2																																																			
2	Annual Monitoring	08/05/2020	01/10/2020																																																
3	Transfer from MPhil to PhD	26/06/2020	01/10/2020																																																
4	Ethical Approval	10/10/2020	15/10/2021																																																
5	Literature Review	14/12/2020	14/09/2021																																																
6	Method	01/10/2021	01/05/2022																																																
7	Data Collection	01/11/2021	01/08/2022																																																
8	Data Analysis	05/08/2022	20/01/2023																																																
Stage 3																																																			
9	Writing Thesis	20/01/2023	20/09/2023																																																
10	Submit Thesis	20/09/2023	25/09/2023																																																
11	Viva Voce Examination	15/12/2023	15/06/2024																																																
12	Conferment	01/07/2024	30/09/2024																																																

- Late enrollment
- Stage 1
- Stage 2
- Stage 3
- Transfer from MPhil to PhD
- Annual Monitoring
- Ethical Approval
- Viva Voce Examination
- Conferment

3.5.2. Research Sampling Frame: Sample Size and Justification

This research used a qualitative approach to provide clarification by focusing more on understanding the contextual factors such as organisational and cultural factors; that influence the development of TVNs in Kuwait, Qatar, Jordan, and Egypt. The sampling strategy in qualitative research explores a target population that directly represents the cultural and social aspects (Mohajan, 2018). Having sufficient samples is necessary to enrich the information and then achieve data sufficiency or what is known as data saturation. The word saturation in data collection refers to the point when no additional insights are developed from the research questions (Guest, Bunce and Johnson, 2006). In qualitative research, data saturation is considered a criterion to avoid repetitive data in a large sample. However, developing insight from the data depends on personal understanding and thought, therefore reaching saturation points differs from one person to another. Despite that, Hennink et al. (2017) stressed that the accuracy of qualitative samples can be assessed by achieving a saturation point. It is always identified as the guiding principle that determines sample sizes in qualitative research, further, it is considered an indicator of effective sampling (*ibid*); by assessing the comprehensiveness and adequacy of a purposive sample (Morse, 2015). According to O'Reilly and Parker (2013) and Walker (2012), data saturation is reached when the collected data are sufficient to replicate the research and coding is no longer feasible. For example, collecting data until no further issues emerge. The researcher must maintain a saturation point as an indicator of having sufficient data that can be categorised into different themes without repetition. Hence, when all relevant themes are explored and it is not possible to generate new themes, this indicates that data saturation is achieved. Coleman (2019) stated a research instrument such as an interview should have a range of intrapersonal, interpersonal, structural, contextual, operational, and ethical factors. Thus, it requires capturing the interviewee's beliefs, values, behaviour, experience, culture, and other aspects, which can be achieved through data saturation. However, it is important to rely on factual evidence such as reports or clarification of what has been achieved (Hennink and Kaiser, 2022). In this research snowball sample was used to recruit further participants until data sufficiency. The evidence of achieving the saturation point has been provided in the analysis chapter in the form of themes and sub-themes.

Considering all the previous perspectives into account while planning for the sampling, the implication of applying purposive sampling allows the researcher to identify the relevant decision-makers and gatekeepers in Kuwait, Qatar, Jordan, and Egypt.

3.5.2.1 Changes in the Sample Size

Initial sample size

Different groups were selected through a collaboration between hospital management (Section 3.6.3, page: 112). The sample size has been developed based on the research design, purpose, and further inclusion and exclusion criteria. The inclusion criteria were divided into administrative positions as policymakers or decision-makers and clinical positions with their background in the health profession, such as nurses or doctors. The participants working in the dermatology or surgical department have more exposure to wounds and skin problems (Bickers et al., 2006). They are seniors or juniors, between 25 to 55 years old including both genders (male and female) with a diploma, bachelor, or higher degree. Further, participants are required to have working experience in Kuwait along with the ability to speak Arabic or English language. For the exclusion criteria, anyone not fitting the inclusion criteria has been excluded. In addition, it excludes bias and discrimination. Therefore, the preliminary sample size was 18 participants, selected according to their hierarchical levels such as directors, doctors and nurses in clinical and administrative positions, as presented in Table 3.5. However, while executing the data collection method, there were some limitations such as gatekeeping that prevented accessing nurses and other limitations based on cultural aspects including the lack of willingness to participate by the respondents.

Table 3.5: Initial Research Participants

No.	Classification	Number
1.	**General / Specialized Nurses**	4
2.	**Nurses-Team Leaders**	2
3.	**Head Nurses**	2
4.	**Nursing Assistant Director**	2
5.	**Hospital Nursing Directors**	2
6.	**Nursing Directorate Directors**	1
7.	**Doctors**	2
8.	**Hospital Directors**	2
9.	**Policymakers in the Ministry of Health**	1
Total		18

After having first-hand experience, some limitations emerged which led to a lack of participants from Kuwait as explained in (Chapter One, Section: 1.1, pages: 3-5). Therefore, to have a rich perspective between professionals within organisations, further participants in

clinical and administration positions were considered to provide both depth and diversity, based on a snowball sampling, the opted sample size changed from 18 to 32 as given in Table 3.6. Moreover, the participants from Qatar, Egypt and Jordan were recruited based on the decision maker /Kuwait referral and recommendation, hence, the participants were recruited through email (further information will be in Section 3.6.3, page: 112).

Table 3.6: Revised Research Participants

No.	Classification	Number
1.	**General / Specialised Nurses**	8
2.	**Nurses-Team Leaders**	4
3.	**Head Nurses**	4
4.	**Nursing Assistant Director**	4
5.	**Hospital Nursing Directors**	4
6.	**Nursing Directorate Directors**	2
7.	**Doctors**	2
8.	**Hospital Directors**	2
9.	**Policymakers in the Ministry of Health**	2
Total		32

3.5.2.2 Reflection on the Sampling Process

While executing the data collection method, there were a few challenges in the process of data collection in the case of Kuwait and other limitations based on organisational and cultural aspects. There had been immense reluctance on account of respondents to participate in the interview. I had experienced a certain level of fear and a stern issue of hesitation from those who were arranged by the organisation's management. The potential participants were contacted through email, however, in some cases, the potential respondent agreed to the interview and the consent along with the participant's information sheet delivered through email, upon which the time for the interview was decided based on the participant's convenience. Despite this, there was a last-minute retraction from the commitment and other reasons for not participating such as difficulties dealing with technology (Microsoft Teams), which reflect organisational behaviour and culture (Chapter Two, Sections: 2.3.5.1.1, page: 53; Section: 2.3.5.1.2, page: 54). In one instance the potential participant was sceptical about the English origin of the supervisors. He mentioned:

"Why are people from the UK aiming to scrutinise the nurse's practices in Kuwait".

This also reflects organisational defensive behaviours (Chapter Two, Section: 2.3.5.1.2, page: 55). Applying defensive behaviour by the employee would be wise such as avoiding talking to external surveyors or researchers to avoid judgment, however, for the organisation, it is considered to be a barrier to improvement. Meanwhile, if individuals stayed silent or refused to share their thoughts it would be challenging to develop TVNs. For example, nurses must have a voice for change, if all of them refuse to discuss or share their thoughts, this could hinder nursing development. These issues led to the lack of participants from Kuwait hence leading to insufficient sample size. Overall, these issues led to a change in research scope for further data. The new scope of the research is expanded to three Middle Eastern Countries (Qatar, Jordan, and Egypt) in addition to Kuwait; so that there can be sufficient data for analysis and discussion. The selection for these countries has been discussed in (Chapter One, Section: 1.7, page: 12).

3.5.2.3 Inclusion and Exclusion

The inclusion and exclusion criteria were modified to fit the new scope of the research accordingly:

- **For the inclusion criteria**: the participants have working experience in Kuwait, Qatar, Jordan, and Egypt, further divided into administrative positions such as decision-makers including hospital directors. For clinical positions nurses or doctors, who were working in the dermatology or surgical department; and have more exposure to wounds and skin problems. Seniors or juniors, between 25 to 55 years old including both genders (male and female) with a diploma, bachelor, or higher degree and speaking Arabic or English language. Additionally, the participants from Kuwait, Qatar, Jordan, and Egypt are nationals or international.
- **For the exclusion criteria:** anyone not fitting the inclusion criteria has been excluded. Furthermore, any type of bias and discrimination were avoided.

3.5.3. Sampling to Qualitative Research Validity

The selection of the previous sampling methods enhances the validity of the interviews. According to Robinson (2014), well-conducted sampling boosts transparency and the coherence of the qualitative research as well as rigour, impact, and importance. This ultimately eliminates bias and generalisation of findings, it is considered as a significant criterion to assess the validity of the research. Yardley (2000) stated that more consideration was given to the

context of the sample, rather than the sample size itself, where the researcher would be able to demonstrate the rigour of the sample and gather the required information for comprehensive analysis. Taking into account that in Kuwait and Qatar, the majority of nurses come from different backgrounds or non-Arabic speakers (Chapter Two, Sections: 2.10.3, page: 73; Section: 2.10.4, page: 75), hence, it is an opportunity to consider people from different countries to enhance the breadth of the data. In qualitative research, it is important to ensure that the data is efficient and valuable, therefore, conducting the appropriate sampling strategy and approach will enhance rigour, as will be demonstrated in this chapter. In contrast, another vital criterion in qualitative research is 'transparency' in the research process and related to the explicitly of the research findings; that will be presented in the final research report. Thus, incorporates meeting sample strategy, sample size and sample sourcing. Maintaining those criteria would enhance the validity of the research, however, the research could be influenced by the researcher's own background and network (*ibid*). Consequently, the recruitment process and the participant's selection could be affected too. The researcher's own background in the nursing profession along with association with the specific hospital might lead to focus on people from the same profession and organisation in general. In order to avoid this, the selection of the respondents had been left to the discretion of the M.O.H./Kuwait and the hospital management (Section 3.5.1, page: 104). However, to ensure transparency in the research process, the researcher's professional background was shared with the participants through email prior to the interview.

3.6. Data Collection

3.6.1. Impact of COVID-19 on the Research Instrument

The pandemic of COVID-19 affected the research methods significantly, as a result, the research methods had been changed three times. The original research plan was designed to focus on NUH, UK and SAUC, Kuwait, to explore and understand the role of TVNs in the UK and then develop this in Kuwait as explained in (Chapter One, Section: 1.1, pages: 3-5). Therefore, the initial research methods are illustrated in Figure 3.4. Further, the designed method changed as shown in Figure 3.5.

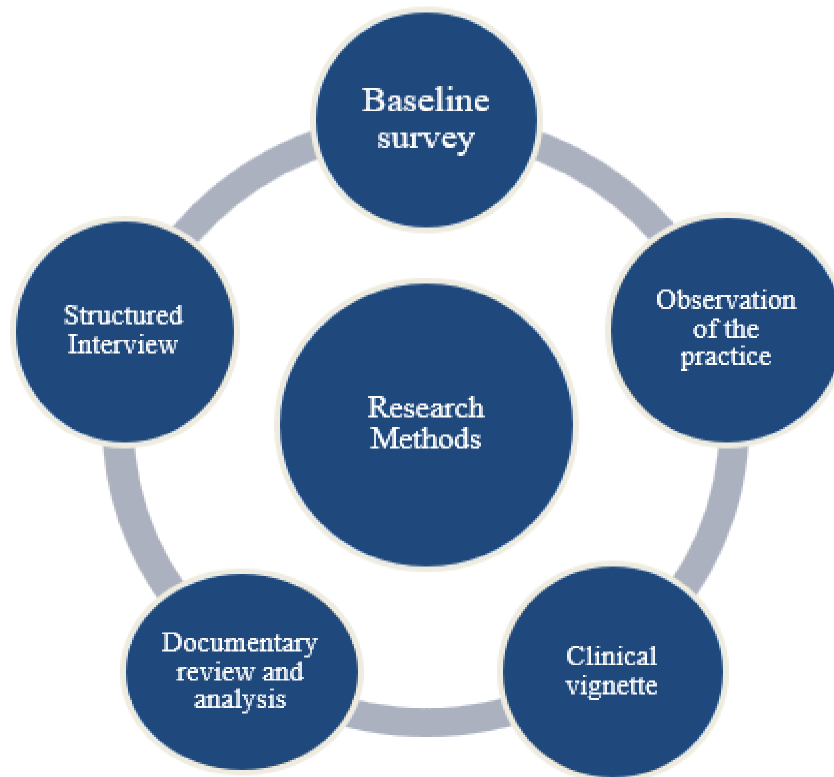


Figure 3.4: Initial Research Method

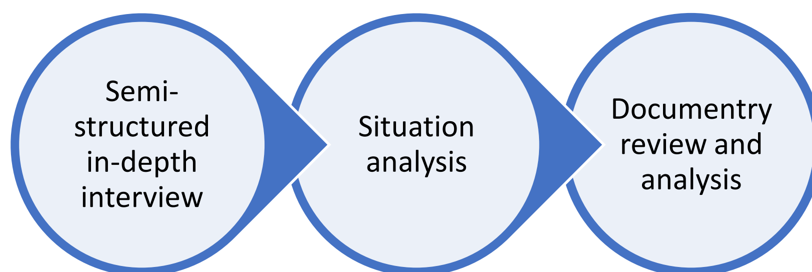


Figure 3.5: Research Methods

3.6.2. Reflection on the Impact of COVID-19

It was rational to change the research plan and methods according to the emerging circumstances. These changes in the research design and execution of the methods were associated with opportunities and some limitations as follows:

- **Opportunities:** Selecting more countries and the changes in the research provides a wider view of the nursing profession in the respective countries which helps me to understand the issues related to the nursing profession especially related to wound management.
- **Limitation:** The initial plan for the research is to be completed in three years, however, the impact of COVID and the following aspects altered the timeline. The lack of participants from Kuwait made me feel anxious initially, although it was an opportunity to explore the reason behind this behaviour and it was part of the learning process.

3.6.3. Data Collection and Research Instrument

In this research, interviews were conducted to explore the nurse's role related to skin integrity and wound management in Kuwait, Qatar, Jordan, and Egypt. The objective of the research is largely explored through the interviews; hence it is deemed to be the most logical research method (Coleman, 2019). It is divided into three stages (Easwaramoorthy and Zarinpoush, 2006), as shown in Figure 3.6. Those stages help to provide information about the research to the interviewees, to gain their trust and to build a rapport. It is also important for the interviewer to know who is interviewing, as there are two groups that the researcher is aiming to interview. First, group (A) participants were in administrative positions and group (B) participants were in clinical positions who had experience in dealing with wounds, further working in any department in the hospital. Therefore, the interview set of questions varies depending on the role of the participants and how this can serve the research to understand the development of nurses' role in wound management in Kuwait, Qatar, Jordan, and Egypt.

Kvale (2006) asserts that interviewing is a democratic and emancipating form of social research, it is emergent and inductive, thus, giving the opportunity to present the opinions of those whose voices usually fail to be heard. The interview outcome could help in changing social practice through knowledge translation (Cordeiro and Soares, 2016). For example, the interview could help to understand individuals’ concerns and fears of the current working system, and then determine what needs to be changed in their practice. According to Fay

(1996), the area of social sciences is associated with human thoughts regarding the social world, and it starts with individual broad ideas and thoughts regarding their social boundaries. However, Alvesson (2003) argued that some individuals still considered interviews as an inaccurate, simple, and insufficient tool for generating data. For example, if the interview is conducted with a limited number of questions it leads to exploring a limited number of dimensions along with the subjective perspective provided by each interviewee. Ryan and Bernard (2003) and Cohen, Manion and Morrison (2011) emphasised that an in-depth interview is a flexible data collection tool, that enables the researcher to move the conversation from one to another relevant aspect. It is a significant data collection approach that provides direction for the interviewer, further, it follows a specific structure and sequence. Likewise, Anderson and Jack (2003) and Turner and Schmidt (2022) stated that interview questions are interrelated and the answer to the first question will logically lead to the other questions.

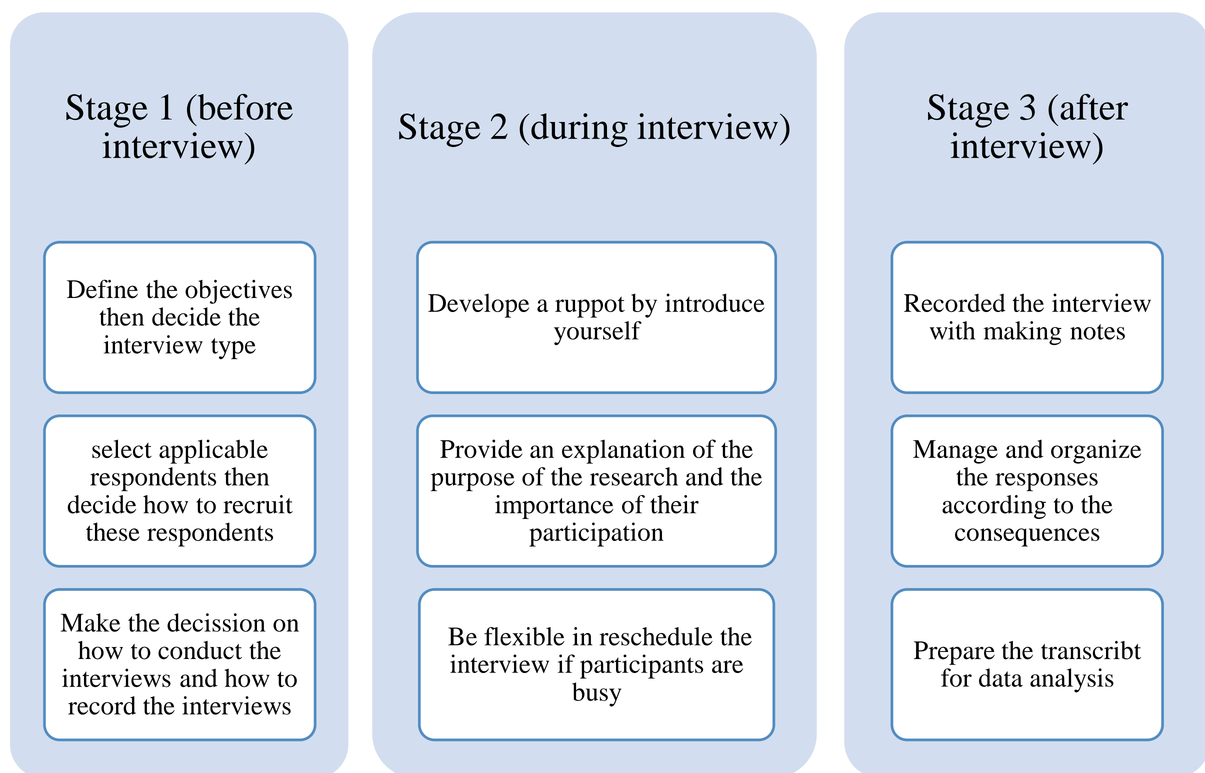


Figure 3.6: Interview Stages as adopted from Easwaramoorthy and Zarinpoush (2006)

An interview is divided into structured and semi-structured. Structured interviews are more dominant in quantitative studies, the interviewer can apply them when having a clear

understanding of the issue and needs to strengthen the information baseline (Phellas, Bloch and Seale, 2011). In contrast, semi-structured interviews are known as a combination of structured and unstructured interviews. In this type, some questions could be predetermined, whereas others are not. The interviewer could use this type of interview to provide more understanding of the issue and lead to discovering new aspects that have not been anticipated before (Husband, 2020). Bryman (2016) and Mears (2017) emphasised that a semi-structured in-depth interview is commonly used in healthcare research, further, it is a reliable method for data collection in qualitative research. It facilitates the researcher to explore and understand the issue in depth from the responses. Therefore, conducting semi-structured interviews will help to draw attention to the issue, it also allows the interviewer to start an open conversation without limitation with the participants (Brown and Danaher, 2019). However, the researcher has to be aware of the fact that a semi-structured interview can potentially lead to controlling the thoughts of the interviewee if questions are too controlling. It implies that the interview design can avoid this potential limitation. Furthermore, it is a valuable research tool that enables the researchers to present their thoughts or ideas related to the topic in sequences, this will develop free-ranging conversations (Galletta, 2013). This will enable the participants to speak freely and share their points of view according to the designated direction, which might make an unexpected response related to the investigated issue or might raise a newly relevant issue. For example, if the interviewer asks about the working environment, then a range of areas such as consecutive working hours or other issues might emerge. Moreover, interviews allow the researcher to take account of the interviewee's body language and intrinsic aspects of the communication. As a result, this research has the potential to comprehensively reveal complex concepts or gaps in the healthcare system. Which could be associated with some organisational behaviours and culture like fear and silence (Chapter Two, Section: 2.3.5.1.1, page: 54).

3.6.4. Interview Strategy

Obtaining detailed information from the key informants is a preliminary factor for a successful interview. The information could be broad and random, but the researcher can take account of actual responses and cultural or behavioural aspects that make the findings in-depth and reliable. This research uses an exploratory approach, hence, pre-planning for the questions and building a rapport to start a conversation are the key elements to enhance the interview's outcome. In this research, the researcher seeks to understand the nursing professional role related to wound management and explores barriers and facilitators to developing TVNs in Kuwait, Qatar, Jordan, and Egypt. Therefore, the interviewer requires an active engagement

with the interviewee by starting a normal conversation, instead of looking at the paper and asking questions. Interviews allow for capturing participants' opinions, including verbal and non-verbal data such as eye and body movements (Griffiths, 2013; Bryman, 2016; Gray, 2018). Moreover, to ensure that the interview is conducted effectively; the interviewer must have various skills such as: being flexible and patient, maintaining openness during the interview and avoiding judgment or criticism during communication. Being a good observer and listener helps the interviewer in reflection and interpretation. As well as allows participants to talk and explain their points, without interruption and jumping to conclusions. Also, the interviewer must be fully attending to what the participants have said and reflecting upon what has been discussed.

3.6.4.1. Topic Guide: Developing Research Questions

As part of the planning for the research, after deciding what type of interview to conduct, the researchers must plan for the questions before conducting the main interviews. This is identified as a topic guide, where the researcher plans for the questions based on the research aim and objectives, to avoid irrelevant answers (Qu and Dumay, 2011). Hence, the researcher must have clear ideas about what is required to achieve through content mapping and content mining questions. Content mapping questions facilitate the researcher to identify the issues that concern the participant (Newcomer, Hatry and Wholey, 2015). For example, the rational and coherent between questions. On the other hand, exploring the issue in detail from the participants to develop an in-depth understanding is called content mining questions (*ibid*). As an example, ask the participants for more information about their role in managing wounds. Both techniques are used to develop the research questions, it involve different techniques that aim to achieve an in-depth understanding and the breadth of coverage across issues. For example, develop follow-up questions, for more explanation and description of the responses. Therefore, the questions need to be clear, focused, and relevant to the investigated area, the questions must be meaningful, not too broad, or too narrow and developed to answer the research aim and questions (see Appendix 3.1).

3.7. Data Collection Process

Technology helped to conduct video or audio virtual meetings via Microsoft Teams and other programs, and this allowed participants from worldwide. Therefore, in this research consideration was given to the virtual interviews due to the pandemic of COVID-19 and the associated health restrictions, to ensure the safety of both the researcher and participants. Also, based on the different geographical locations of the respondents and financial limitations, virtual interviews have been deemed to be cost-effective compared to other methods. For example, in face-to-face interviews, the researcher is required to be present physically in the organisation. This will include the cost of a ticket from the UK to Kuwait which is around £2300. In contrast, virtual interviews required only downloading certain platforms such as Microsoft Teams, which can be installed without a fee on PCs, or any electronic portable device. Besides, recording and avoiding distraction from the surrounding environment is more possible in virtual interviews (Lee et al., 2021). However, conducting interviews virtually might be unfavourable and some researchers prefer to conduct the interview in person to ensure the quality of data (Rubin and Rubin, 2011). Qualitative research enhances the researcher's exposure to social life and further develops their ability to address the research gap based on participants' realities (Seale, 2002). It focuses on understanding the complexity of the responses, which requires understanding human behaviour and expression. For example, in virtual interviews, there is a risk of inadequate responses due to communication difficulties and poor internet connection or other distractions like children or sitting in a public place which could lead to misunderstanding of the questions. Then, it will be difficult to capture the interviewees' emotions and feelings. According to Gray (2018), in-person interviews are more informal, and the information is more detailed than in a virtual interview. It also provides more understanding without the distraction or loss of internet connections. Despite that, looking for virtual interviews as an alternative to face-to-face interviews through (Microsoft Teams) is more convenient in this research, to communicate with the participants from different geographical locations like Kuwait, Qatar, Jordan, and Egypt, it also facilitates conducting the interviews at any time based on participants convenient.

3.7.1. Interviews

Research interviews are divided into two phases:

3.7.1.1 Phase One: Piloting

Performing a small-scale test exploration of the research methods such as a survey or a questionnaire, before starting the methods on a large scale is known as a preliminary or pilot study (Hazzi and Maldaon, 2015; In, 2017). A pilot study aims to train the researcher on how to conduct the research before initiating the actual study, which helps to develop the researcher's skills while conducting interviews. It provides guidance to follow certain methods or procedures. Also enables the interviewer to reflect upon themselves, if comfortable with the research questions or require some modification. Beach and Galda (2001), described piloting as a process of verifying the effectiveness of questions. This involves translating research questions into simple and clear forms for the participants It also assists the researcher in eliminating mistakes and confusion related to the question's content, by changing questions prior to actual interviews. Piloting is also a useful tool to assess the feasibility of the research (Snyder et al., 2014). It can be applied to different research types, such as qualitative or quantitative research. Janghorban, Latifnejad and Taghipour (2014) underlined the advantages of a pilot study, which can be used for various reasons as illustrated in Figure 3.7. The limitations of recruiting could be explored through the pilot study, for example, cultural or religious limitations, lack of interest in participating in research, or lack of time. In qualitative research, piloting is conducted frequently in order to assure the effectiveness of the research tools, to serve the purpose of the qualitative research (Malmqvist et al., 2019). For example, during the COVID-19 pandemic, selecting "participant observation" as a tool for collecting data from the hospital was inapplicable, due to the health restriction. Sometimes the research tools could take more time to perform such as Face-to-Face interviews depending on the participant's willingness. Besides, some participants would prefer questionnaires or surveys instead of interviews if the investigated areas are sensitive. For example, asking about sexual harassment, violence, or politics. Therefore, a pilot study helps the researcher to deal effectively with those limitations and find some alternatives.

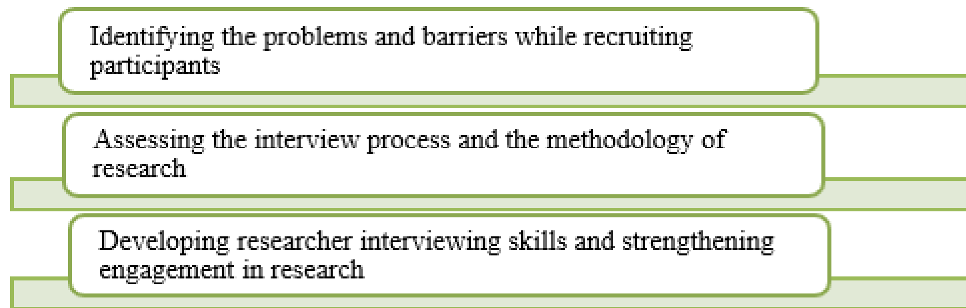


Figure 3.7: **Advantages of a Pilot Study (Janghorban, Latifnejad and Taghipour, 2014)**

Justifying the sample size is significant in the pilot study to investigate the research methods. Therefore, the pilot study redesigns the sampling strategy according to the research needs. A pilot study can be applied in social science research as a preparation for the main study and it represents small-scale versions or trial runs (Polit et al., 2001). Therefore, after obtaining ethical approval from the University's Ethical Department (more details about ethical aspects in Section: 3.10, page: 138) and the M.O.H. /Kuwait, a total of five virtual semi-structured in-depth interviews were conducted through Microsoft Teams as a pilot study prior to the main process of data collection. Considering the delay in the ethical approval and time factor, it was more convenient to select the sample from Kuwait, the sample was more accessible as this saved time to prepare for the main interviews. The participants have been communicated via email and recruited based on their interests, considering their experience and their role as a gatekeeper such as nurses at different hierarchical levels in health organisations of Kuwait. The sample size for the pilot study was five as given in Table 3.7.

Table 3.7: Sample Size for the Pilot Study

No.	Hierarchical Classification	Experience	Total number	Sex	Health organisation
1	Nursing Director	36 years	1	Male	General Hospital
2	Assistant Director of Nursing	20 years	1	Female	General Hospital
3	In-charge Nurse	15years	1	Male	Surgical department / General hospital
4	General Nurses	15 years	1	Male	Uro-surgery department / General hospital
5	Quality Nurse	8 years	1	Male	Quality and accreditation department / General hospital

Reflections on the pilot study

- The first interview was a little stressful because I conducted an interview through Microsoft Teams for the first time. I was not familiar with the programme, and I was not able to record the interviews.
- The questions were in the English language, it was challenging to translate the questions and explain all the questions in Arabic for some participants. It consumes more time than I expected.
- Some of the questions in the interview were not clear and needed to be reframed to get richer information. Further, some of the questions have a similar meaning, therefore I need to review the questions to resolve all those issues.

3.7.1.2 Phase Two: Conducting Semi-Structured In-depth Interview

The research's ethical approval was granted in October 2021 before starting data collection. After getting ethical approval from Nottingham Trent University, the (MOH) in Kuwait approved and disseminated an invitation to all the governmental general hospitals (six general hospitals, one specialised centre for skin diseases and one specialised centre for plastic surgery and skin diseases) to facilitate the process of data collection. After assessment and based on the research requirement and the availability of the staff. The hospital's management in Kuwait arranges for the staff's participation. This is done by circulating an invitation internally to the surgical and dermatology departments for nurses' and doctors' participation. The participants from Qatar, Egypt and Jordan were contacted via email and recruited through the gatekeepers and policymaker channels in Kuwait. Prior to the interview, a consent form along with the participants' information sheet were disseminated through emails, to obtain their written agreement and confidentiality, along with ensuring that the participants understood the research aim and data collection process. The participants are volunteers and based on their interests they were recruited. Maintaining the interviewees in their comfort zone was necessary, hence, recording and video calls were optional. The participants were classified into groups A and B (Section: 3.6.3., page: 112), more explanation of this is given in Figure 3.8.

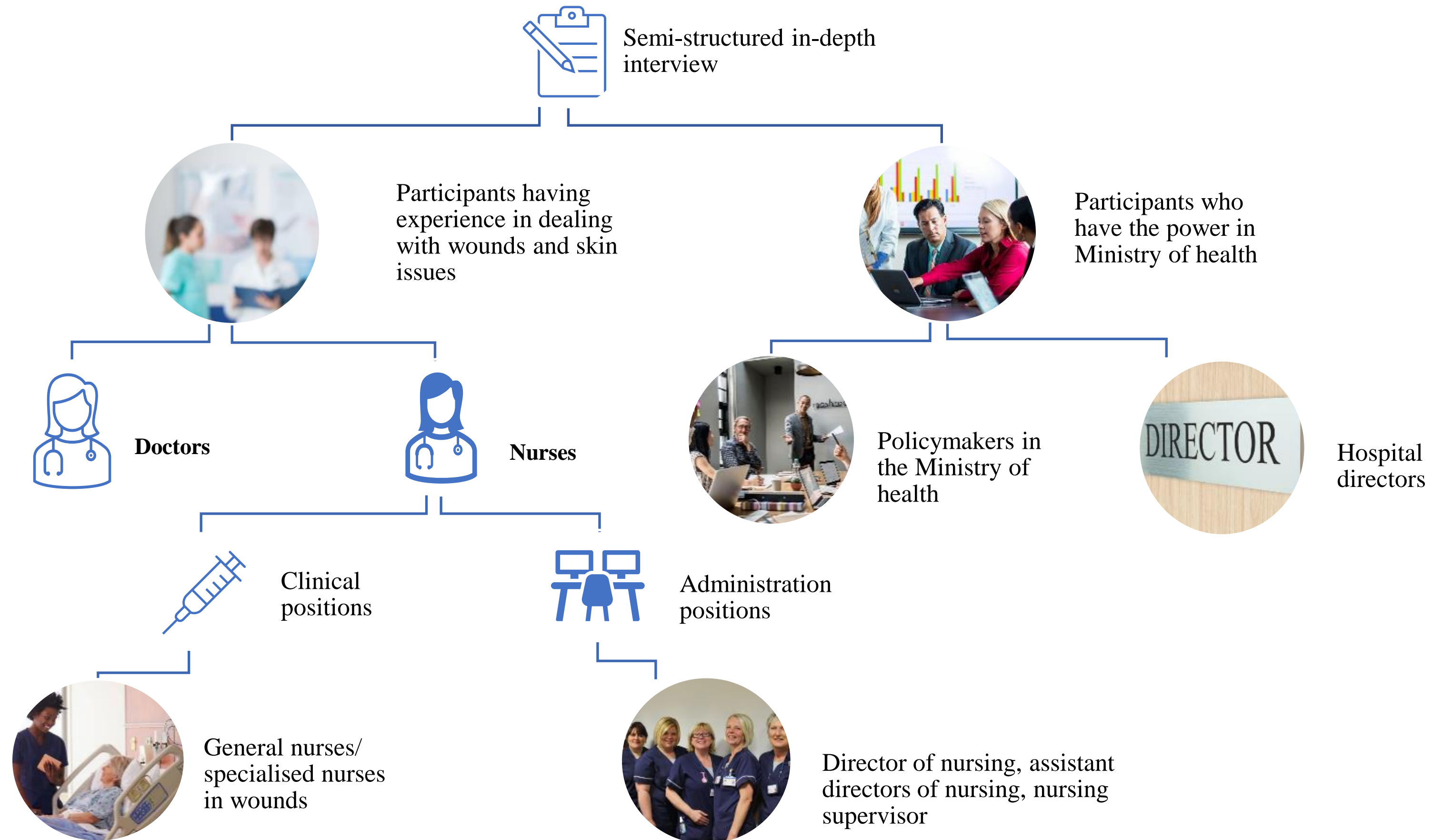


Figure 3.8: Classification of the Participants Group A and B

The priorities of this research have been changed several times depending on the research circumstances. For example, the data collection process cannot finish quickly if there are insufficient responses. In order to progress in this research, personal judgement was applied to allocate the time for writing the methods and methodology chapter and at the same time working on data collection as illustrated in Table 3.4, page:106. Sometimes, the allocated time is not sufficient, or new things emerge, so this requires flexibility in making the timeline, considering the participant's availability and some challenges at a personal level. In accordance with the research timeline, the data collection is divided into three rounds as illustrated in Figure 3.9.

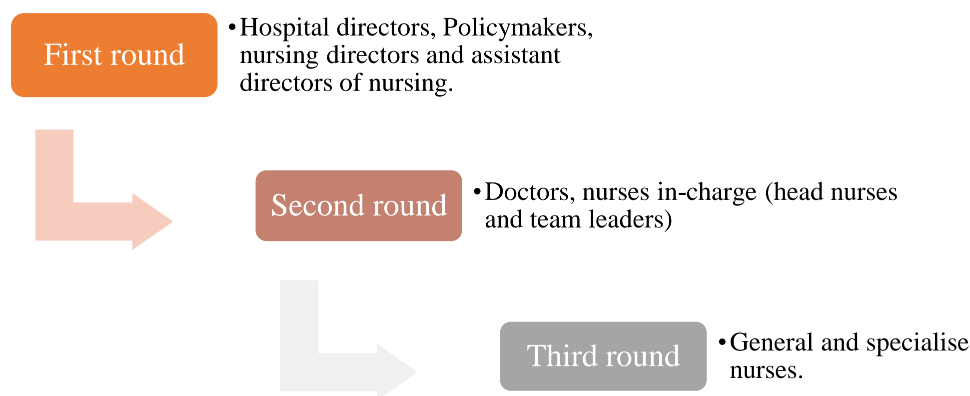


Figure 3.9: Data Collection Rounds

The interview process is divided into phases one and two as illustrated in Table 3.8. These interviews can lead to different stances by increasing the awareness of nursing professionalisation and exploring the personal experiences of nurses, regarding the current and actual practices in wound management. Further, understanding of the issue behind the development of TVNs, through authorised people in the M.O.H. and the decision makers. The research questions were developed in Arabic and English languages. The questions were kept simple; so those respondents could understand the context of the questions. Asking general questions such as how your day or some bio-data questions such as the role of the participants, served two purposes in the research. First, to start a conversation and break the ice between both the interviewee and interviewer. Then, to understand the background of the participants, and how this could influence the development of TVNs in Kuwait, Qatar, Jordan, and Egypt.

Table 3.8: **Interview Process**

Process	Phase One	Phase Two
Philosophical stand	Interpretivist	Interpretivist
Methodology	Qualitative	Qualitative
Methods	Semi-Structured In-Depth Interview (Virtual)	Semi-Structured In-Depth Interview (Virtual)
Sampling	Purposive Sampling and Snowballing	Snowballing
Sample size	17	15
Participants	Policy Makers, Hospital directors, Nurses and Doctors	Nurses and Doctors
Location	Kuwait and Qatar	Egypt and Jordan
Focus of Research Questions	-Discuss the feasibility of developing specialist nurses in tissue viability from different perspectives. -Understand the opportunities and challenges. -Explore the organisational, cultural, and contextual factors that influence the nursing profession and developing TVNs.	-Discuss the feasibility of developing specialist nurses in tissue viability from different perspectives. -Understand the opportunities and challenges. -Explore the organisational, cultural, and contextual factors that influence the development of TVNs and the nursing profession.
Data Analysis	Thematic Analysis	Thematic Analysis

Data collection started in November 2021 and lasted till August 2022; therefore, semi-structured in-depth interviews were obtained virtually through Microsoft Teams, from a total of 32 participants from Kuwait, Qatar, Jordan, and Egypt. The final sample size is given in Table 3.9. The duration for each interview was between 40 minutes to 1 hour approximately. The interviews were conducted weekly and monthly at different times of the day, keeping in account 4 hours differences in the time between the Middle East (Participants) and the UK (Researcher). Some interviews were conducted at midnight or early morning based on the participants' preferences and their work commitments. Some nurses preferred to interview during their night shift due to less work pressure. Directly, the transcripts and reflections were

written upon each interview, to help in the analysis. The data collection process is shown in Figure 3.10

Table 3.9: Final Plan for Recruiting Participants

No.	Classification	Number	Kuwait	Qatar	Jordan	Egypt
1.	**General / Specialised Nurses**	8	7	2	4	2
2.	**Nurses-Team Leaders**	4	2	4	2	1
3.	**Head Nurses**	4	2	11		
4.	**Nursing Assistant Director**	4	NA			
5.	**Hospital Nursing Directors**	4	3	NA	NA	
6.	**Nursing Directorate Directors**	2	NA		NA	
7.	**Doctors**	2	1			NA
8.	**Hospital Directors**	2	1			
9.	**Policymakers in the Ministry of Health**	2	1		NA	
Total		**32**	16	8	5	3

No access for the participants (red)   Not Available (NA)

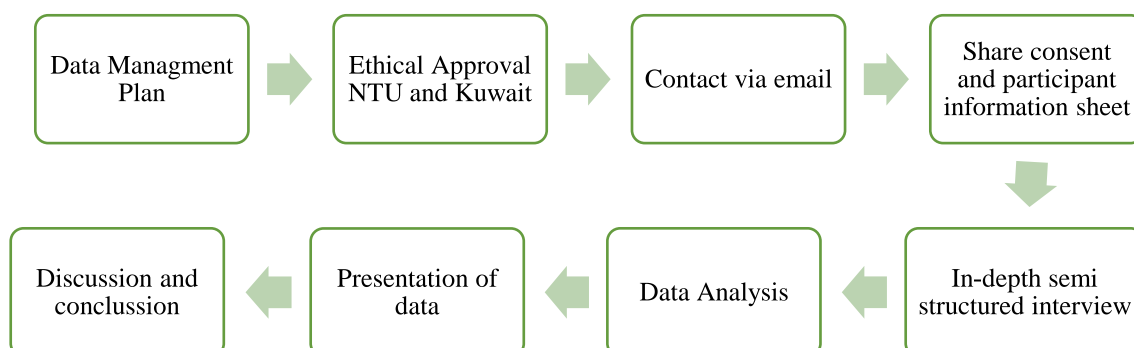


Figure 3.10: Process of Data Collection

3.8. Data Management and Transcribing Interviews Data

3.8.1. Data Management

Dealing and maintaining the data required an efficient plan to ensure that data is valid and can be reused in the future. Therefore, the data management plan is a plan used to summarise the research process and provide a clear structure on how to manage and share the research data during and after completing the research (Dabrowski, 2018). The plan includes a description of the collected data, such as the type of data and how documented, shared, stored and preserved (Burnette, Williams and Imker, 2016). It provides guidance on how to deal with the research data as well as organising and protecting data. It gives value to the data by making it more understandable and ascertainable. Further, it is an efficient practice that provides access to data (Nicholls et al., 2014). Therefore, for this research, a Data Management Plan (DMP) has been written and approved by the University in May 2020. In accordance with changes in the research, the plan has been modified in order to provide efficient and compatible data. This DMP provides detailed information about the research by defining the data such as what source of methods is applied and if any software is used, copyright, compliance, and institutional ownership. In addition, legal and ethical conditions were included in the plan (see Appendix 3.2).

3.8.2. Transcribing Interview Data

Transcription is a significant action in qualitative research that is used for the analysis and representation of the language. It is designed to capture the meanings of naturally occurring phenomena, it is also used to unpack the complicatedness of those meanings (McLellan, MacQueen and Neidig, 2003). It captures individual experiences, beliefs, values, feelings, and thoughts by talking or constructing conversations between the participants and the researcher through the interview (Lester, Cho and Lochmiller, 2020). Transcription is the act of representing the originally recorded data in a written form, along with analysing and interpreting instances of these data (*ibid*). Therefore, it is very important for the researcher to organise and manage those transcripts effectively by distributing them in folders with labelling according to the country as will be explained later to facilitate data interpretation and representation while maintaining confidentiality. The data has been pseudonymised, for example, interview transcripts have been labelled using a unique identifier/false name assigned to the participant. This illustrates that transcription is not straightforward but needs some actions and attempts from the researcher to generate trustworthy findings. Fink (2000) asserted

that the transcription process requires reading and reviewing the data more than one time to get a sense of the information and generate readable and meaningful data. It requires concentration while listening and asking, it also needs to observe the participant's movements and expressions which could help in the interpretation. After reviewing the data, it is important to remove unnecessary information to avoid confusion. Hence, in this research the responses have been reviewed intensively to ensure the rigour of the data for example, unnecessary information that is not relevant to the research has been removed, also, to increase the richness and breadth of data repeated information has been removed for example, sometimes the respondents give similar responses or not relevant responses to the question. Hence, after each interview, the reflections were written upon each interview this also helps in interpretation and getting a sense of the respondent's responses which facilitates transcribing the data into themes. For more clarification, follow-up interviews have been arranged with the respondents. Additionally, the researcher makes sure that the data are accurate by reviewing them again and then accordingly develops the themes as will be explained next.

3.9. Data Analysis

Generating a convenient data analysis is a complicated process that involves selecting an appropriate research method along with representing the data as knowledge. Data analysis helps in transforming the raw data from the data collection tool into meaningful results (Morse, Linda and Niehaus, 2009). It helps in explaining the information in detail to make things clear to the reader and then improve the reader's understanding. It includes developing themes, concepts and interpretations that are embedded via the interview. The analysis in qualitative research requires coding, primary read-through of the database, development of themes, forming an interpretation of themes and presenting the data. All those steps are interrelated and work collectively to generate a meaningful outcome (Creswell and Poth, 2018). However, not all the data have meaning, some are nuances and subtleties. The efficiency of the analysed data could be enhanced by preparing and managing the data from the transcripts, recording it into different themes and then presenting them in an easy and understandable manner. For example, the classification of data in a prominent manner, along with the graphical representation of data could add more value to the analysis and make it more elaborated to the reader. This is done by applying different graphical techniques to make the key information more prominent such as tables or charts.

Beach and Galda (2001) stated that gender, nationality, ethnicity, and income have a significant impact on the participant's responses. For example, the majority of nurses in Kuwait and Qatar come from different backgrounds and ethnic groups. As a result, the researcher might not be able to capture their feelings efficiently. The researcher used verbatim transcription of each interview, which focused on participants' behaviour and gestures throughout the interview. This involved applying various skills to help in understanding and interpretation. For example: using observation as a key element for understanding participants' gestures and movements. According to Kawulich (2005), observation and listening are essential for understanding and interpretation. It also can be tricky when the researcher can build an understanding according to what they have seen or heard. However, to avoid misunderstanding and misperceptions the researcher could ask for clarification. Sometimes moving the hand frequently or repeating words could have some indication, for example, in some cases, individuals prefer to give a diplomatic answer instead of revealing the truth. Therefore, the findings and outcomes of the research analysis might cause harm to the participants, so ethical consideration is considered to protect all the participants and secure participants' details as explained later in the research.

The interview questions were well-developed by using a topic guide as illustrated in section 3.6.4.1 (page: 115). Additional information was obtained related to the participant's biodata as presented in Figure 3.11**.** The interview started with an introduction about the researcher and research. Then with a gentle entry such as "*Tell me about yourself perhaps why you became a nurse?"* It is also important to explore more about the reality of their roles, not just their job description. Like asking:

what is it like working during the pandemic, do you have time to spend with family or to relax?

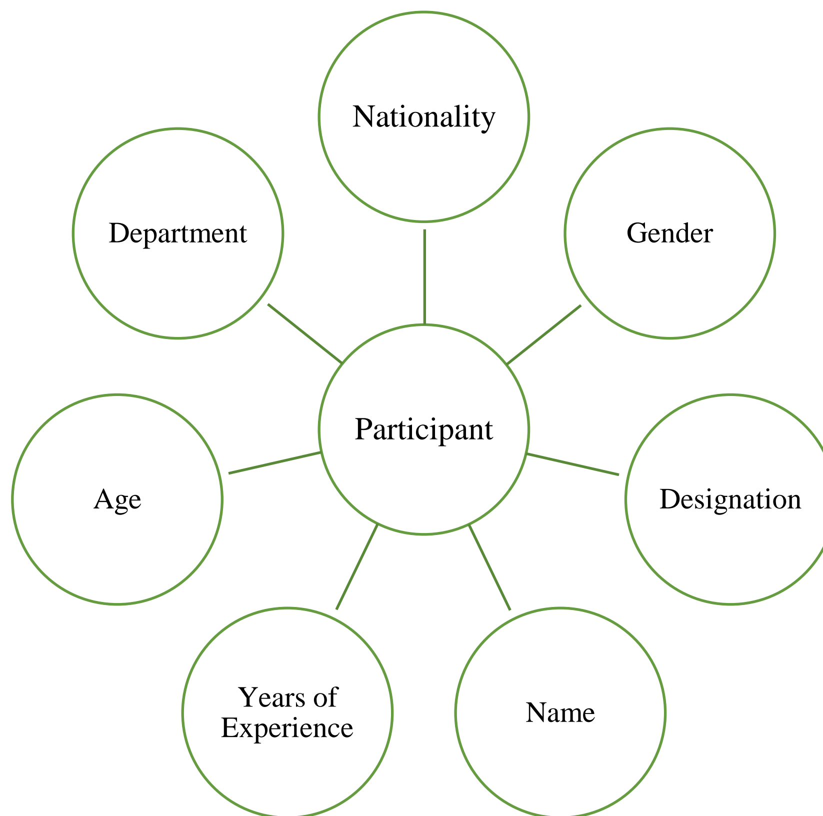


Figure 3.11: Participant's Biodata

Semi-structured in-depth interviews allow the interviewer to acquire more information from the interviewee. For example, start the question with *tell me about*.. or *tell me more…explain your answer* …. This will help to gather more information and show that the researcher is interested in them personally. Audio recording is a significant way of capturing and analysing the data, it helps to ensure the accuracy of transcription (MacLean, Estable, and Meyer, 2004). The analysis process required interpretation and managing the data. Capturing the participant's interview responses via transcripts and reflection enables the researcher to understand the meaning in-depth, which helps the data analysis through an iterative process. For the analysis, video and audio recordings were used according to the participant's convenience. The data in this research was generated from 32 in-depth semi-structured qualitative interviews. Those individuals shared their experiences as nurses, doctors, and decision-makers. The participants provided some details related to their job descriptions and additional information related to their roles. However, most of the answers pertain to the individual's experience of being a nurse and how their role has changed over the years. Further, some participants are doctors, hence, these interviews attempt to explore their attitude toward nurses. Each interview was entirely transcribed by using verbatim. Verbatim transcript

maintains the accuracy of the information along with helping in the data analysis (McMullin, 2023). However, in some situations, when the responses are unclear this affects the quality of the analysis. The uncertainty of some information could reduce the reliability of the data related to the nurse's experience and thoughts. Hence, asking for clarification is important to avoid misconceptions like:

could you repeat it, can you say it again… I am not sure if I understand….

Although the data was transcribed automatically through Microsoft Teams, still there was a discrepancy in the data provided for one participant. Some of the information was missing and some inaccurate. Consequently, each record was listened or watched again to ensure that all the information was transcribed accurately.

3.9.1. Thematic Analysis

In data analysis, the term "theme" refers to vigorously constructed patterns that developed whilst analysing the data, and it plays a significant role in answering a research question, it can be produced inductively or deductively (Kiger and Varpio, 2020). Myers and Avison (2002) highlighted that themes could be determined based on the similarities and contrasts between multiple interviews, also according to subjects endure in different interviews. In this context, thematic analysis is a practical data analysis method, it is employed to analyse textual data and explicate themes. This includes a description of the social reality through coding and designing different themes. According to Braun and Clarke (2012), thematic analysis can be used for various research designs and within different sample sizes, it enables the researcher to answer research questions and address research aims. Boyatzis (1998) stated that thematic analysis delivers rich and detailed information, it has an inductive nature and enables in generating naturally new themes that emerged from the interview. It is an appropriate and powerful data analysis approach that would facilitate understanding the human behaviour and attitude that is associated with the investigated area, it also helps to explore the individual experience as well as their thought process related to the investigated area (Braun and Clarke, 2012; Kiger and Varpio, 2020). Despite that, the reliability of the findings and interpretations in thematic analysis relies significantly on the researcher's understanding and transparency of their paradigmatic orientations and assumptions (Nowell et al., 2017). This approach is a particularly simple and clear method of analysing and presenting data related to the participant's experiences and knowledge in the profession, which has been interpreted to

understand the meaning of the participant's responses. By applying thematic analysis, the researcher became flexible in presenting the data, there is no specific order for presenting the themes, however, the researcher generated the themes according to the importance of issues and commonalities. This helped in understanding the reality of the situation related to the profession. Developing themes could lead to sub-themes and the process of data coding into themes was an extensive practice in which data was developed and analysed manually. Data analysis developed themes according to the literature review and based on the interviewee's narrative. To develop those themes the researcher conducted a six-step process of Braun and Clarke (2006), which is a commonly applied approach in thematic analysis, that provides guidance for the researcher to actively engage throughout the data analysis process. It starts by familiarising yourself with the data and ends by generating the report as follows.

Step 1: Familiarising Yourself with the Data

In this step, the researcher's awareness increases of the data by actively reading and going through the entire data (Vaismoradi et al., 2016; Nowell et al., 2017). For example, in this research, the researcher used the interviews as a data set specifically verbatim data as well as the literature review. At this step, the researcher can be more familiar with the data and emerging themes. It includes reflecting on the interview, writing the transcripts listening to the recordings and then again re-reading transcripts to make sense for the researcher, hence, recognising the main issue. Therefore, this step could consume more time in writing and reading, however, it enhances the researcher's orientation of the aspect (Creswell and Poth, 2018). In this step, the researcher acquired a preliminary idea about the issue, further, it prepares the researcher for the next step which is developing codes.

Step 2: Generating Initial Codes

When the researchers have an idea about each transcript, they construct detailed descriptions of the issue, which will widen their views and thoughts, leading to preparing the codes (Braun and Clarke, 2012). Coding in general used for organising and distinguishing between data, it entails combining the data into small categories and saving them in a specific folder to facilitate data analysis. According to Creswell and Poth (2018), codes can be categorised into 25 up to 30, however, to have a reliable finding the researcher must eliminate unnecessary codes and combine them into five or six themes. Codes represent themes based on different ideas or interests. For the coding process, Grbich (2013) provides guide questions as follows:

- What codes would be expected to fit?
- What new codes are emergent?
- What themes relate to other data sources?

Coding is frequently used in qualitative research; it is about developing a word or short phrase to facilitate the analytic process. It is essential for the researcher to focus on participants' responses which include catchy words and clues. According to Bormann, Hurst and Kelly (2013) sometimes coding might release negative feelings from the emotional regulation in the brain, which generates in the form of clues or repetition of words. Further, verbal and behavioural interpretation of the data, while discourse analysis, focuses on how languages and spoken interactions are used to construct meanings in the social world (Silverman, 2013). Williams and Moser (2019) identified coding as an organised process that enables the researcher to gather, categorise and thematically sort the collected data. It entails well-understanding to avoid overlap with other codes. Codes could have cemented or hidden meanings that explicit messages (Edwards and Carmichael, 2012). Therefore, researchers must be creative with maintaining transparency and simplicity in developing codes, this will facilitate organising and finding the data easily. Stuckey (2015) stated that the process of developing codes is considered to be predetermined and it is used from previous research codes. It can also be derived from research questions or interview transcripts. For example, organising and saving folders based on similarities and differences between the nursing profession in the respective countries. This helped in finding the folder easily when needed and then, developing codes based on the literature review or interview results such as concepts, actions, expressions, and prominent words. The process of developing codes is described as inductive (emergent) and deductive (priori), or it can be a combination of both (Creswell and Poth, 2018). In addition, data coding can be performed manually or by using a specific program, however, coding was done manually in this research.

Step 3: Searching for Themes

The third step of data analysis explores potential themes, this includes examining codes along with the data collection extract. Braun and Clarke (2012) described the data analysis as a house that includes bricks and tile which are referred to as "codes", and the roof and walls of the house are "themes". This implies that identifying themes is an interpretative process that requires identifying how the foundation of that house is built which includes a systematic process of data analysis, comparing and combining data and developing codes. Therefore, the

basic requirement of each theme is to be related to the research aim or questions, further, those themes must be coherent and meaningful.

Step 4: Reviewing Themes

This step provides a clear idea about themes through re-reading and revising codes and themes (Braun and Clarke, 2006). The analytical process is divided into two-level; the first level focuses on the relevance of codes and themes by asking the following questions:

- Does each theme have adequate supporting data?
- Are the data included coherently in supporting that theme?
- Are some themes too large or diverse?

By answering those questions, the researcher was able to identify the cohesion and consistency between themes. The second level is similar to the first level, however, at this level, the researcher seeks to understand the themes and their meaning and importance to the research. The researcher must employ a thematic map accurately and sufficiently to represent the entire body of data (Braun and Clarke, 2006). The data in this research was reviewed and refined according to the needs to generate themes.

Step 5: Defining and Naming Themes

In this step, a narrative description for each theme is developed, further, the names along with the final reports reviewed to ensure they are concise and adequate (Braun and Clarke, 2012). This step requires assigning names to each theme as well as defining themes by providing a concise and coherent narrative description of each aspect. Themes are covered manually. Therefore, the scope and the importance of each theme developed in this step and data extracts were identified too.

Step 6: Producing the Report/Manuscript

This is the final step in the thematic analysis which mainly focuses on writing up the description of findings and the final analysis (Vaismoradi et al., 2016). This step is associated with all the previous steps, starting from reviewing, naming, defining, describing and writing themes. According to Kiger and Varpio (2020), this step of producing the finding is a continuous process of analysis with the interpretation, it is usually used in health studies. The final report must move further than a description of codes and themes, it has to explain based

on why the researcher selected those themes, how the interpretation of data was performed and why it is accurate. It includes narrative and interpretative descriptions for instance providing brief and clear data to support the interpretation with the evidence from the literature.

Data were regrouped and allocated to the relevant theme to assist in answering the research questions. The responses varied from one participant to another, however, all led to the first stance on their experience and role in dealing with skin and wound management and the influences of developing TVNs. The second stance is the healthcare provider's attitude toward nurses such as doctors. Some of the responses were not sufficient and the participants seemed ambivalent or not expressive. As a researcher, more interest showed to the participants in what they were saying, for example being inquisitive after the main question by asking (why, what, how and when). This facilitated gathering more information along with providing breadth and depth. Furthermore, after each interview effort and time was spent to reflect and immediately transcribe the interview, as well as checking the recording and ensuring each was downloaded in a separate file. Each interview was planned in advance, to avoid any interruption, internet connection quality was checked, and a desktop computer was used to conduct the interview, but in case of a problem with the headphones or camera, the backup was available in the form of a phone and laptop.

3.9.2. Presentation of Data

The official language in Kuwait, Qatar, Jordan, and Egypt is Arabic, hence, most of the Arab participants preferred speaking in the Arabic language. Therefore, the interview questions were translated into Arabic language. After finishing the interview, the raw data was transcribed, translated, and reviewed in the English language manually. On the contrary, interviews were conducted in the English language for non-Arab speakers' such as nurses, those nurses are originally from foreign countries such as India or Indonesia but working in Kuwait and Qatar. The data has been pseudonymised, for example, interview transcripts are labelled using a unique identifier/false name assigned to the participant. The participants were divided into groups A and B, however, for more clarity in the analysis, participants were classified into different sub-groups K, Q, E, and J. Further, unique codes were used for the participants' according to the department and role in the health organisation, (Int.) used for the researcher. All the theme-related information is given in the following tables.

Table 3.10: Group A / Identification Codes for Policymakers

No.	Participants (codes)	Role
1	Ha. A.M#K	Assistant Manager
2	Hu. P.M#K	Quality And Accreditation Directorate/ Policymaker

Table 3.11: Group A / Identification Codes for Nursing Directors

No.	Participants (codes)	Role
1	Kh. N.D#K	Director of Nursing
2	Ma. N.D#K	Director of Nursing
3	Fa. N.D#K	Director of Nursing

Table 3.12: Group B / Identification Codes for Nurses and Doctors

No.	Participants (codes)	Role
1.	Wa. U.C#K	Paediatric Consultant
2.	Sa. O.P#K	General Nurse
3.	Th. U.S#K	General Nurse
4.	Nu. U.S#K	General Nurse
5.	Ri.O.P#K	General Nurse
6.	Ti. O.P#K	Team Leader
7.	Al. S#K	Team Leader
8.	Re. O.P#K	Head Nurse
9.	Al. O.P#K	General Nurse
10.	Ri. U.S#K	General Nurse
11.	No. U.S.#K	General Nurse
12.	Me. U.S#Q	Team Leader
13.	Ba. O.T#Q	General Nurse
14.	Sa. S#Q	General Nurse
15.	Dh. I.C#Q	General Nurse

16.	Ni. I.C#Q	General Nurse
17.	El. S#Q	General Nurse
18.	Pe. S#Q	General Nurse
19.	Lu. O.G#Q	General Nurse
20.	Ta.E.R#J	General Nurse
21.	Hu. S#J	General Nurse
22.	Ta. O.T#J	General Nurse
23.	Mo.I.C#J	Team Leader
24.	Sa.IC#J	General Nurse
25.	Ab. U.S#E	Head Nurse
26.	Th. O.P#E	General Nurse
27.	Ah. S#E	General Nurse

The data collected through Microsoft Teams was analysed by using a thematic analysis approach. Immediately, transcriptions were developed in English through Microsoft Teams, however, to assure clarity it is performed manually. The recording was viewed again and further reading and revision were performed to ensure the comprehensiveness and accuracy of the Microsoft Team auto-transcription data. The analysis process started by identifying the relevant keywords and then finding the similarities or relevant answers by continuously reading these transcripts. Then, generate and categorise themes corresponding to different stances. Prior to the presentation, the data was entered, checked, and revised to maintain the quality and avoid overlapping. In addition, it is organised and categorised according to the similarity in folders with assured labelling. Additional and unnecessary data was removed to increase the richness and breadth of data to construct meanings to the social world. For an easy representation of data, Microsoft Excel was employed to develop different graphs and tables. The respondents for semi-structured interviews were analysed manually by using Microsoft Word 11 and Microsoft Excel (Version 2012). In this qualitative study, the participants have been broken down into sub-groups (K, Q, J, and E), more details are in the following tables.

Table 3.13: Group A

Sub-group K: Policymaker and Key Informant

Participants (Codes)	Date	Years of experience	Qualification	Sex	Nationality	Position / Area
Ha. A.M#K	23/1/2022	12 years	Master in international relations of politics	Male	Iraqi	Assistant Manager
Hu. P.M#K	25/1/2022	18 years	MD, ISQua Expert, FEBU	Male	Egyptian	Quality And Accreditation Directorate/ Policymaker

Table 3.14: Group A

Sub-group K: Nursing Directors

Participants (Codes)	Date	Years of experience	Qualification	Sex	Nationality	Position / Area
Kh. N.D#K	2/12/2022	17 Years	Diploma	Male	Kuwaiti	Director of nursing
Ma. N.D#K	3/12/2022	32 Years	Diploma	Male	Kuwaiti	Director of nursing
Fa. N.D#K	05/03/2022	30 Years	Diploma	Female	Kuwaiti	Director of nursing

Table 3.15: Group B

Sub-group K: Nurses and Doctors

Participants (Codes)	Hospital	Date	Years of experience	Qualification	Sex	Nationality	Position/Role
Wa. U.C#K	Specialised Centre	18/2/2022	7 years	Master in international health management, MD, FEBU	Male	Egyptian	Head of the Paediatric Department
Sa. O.P#K	Specialise Centre	5/11/2022	6 years	BSN	Female	Indian	General Nurse
Th. U.S#K	Specialise Centre	6/11/2022	6 years	BSN	Male	Indian	General Nurse
Nu. U.S#K	Specialise Centre	9/11/2022	12 years	BSN	Male	Indonesian	General Nurse
Ri.O.P#K	Specialise Centre	23/11/20222	18 years	Diploma	Female	Indian	General Nurse
No. U.S.#K	Specialise Centre	24/11/2022	18 years	BSN	Male	Indonesian	Team Leader
Ri. U.S#K	Specialise Centre	4/12/2022	10 years	BSN	Female	Indian	Team Leader
Ti. O.P#K	Specialise Centre	9/12/2022	10 years	BSN	Female	Indian	Head Nurse
Al. O.P#K	Specialise Centre	12/12/2022	6 years	BSN	Female	Indian	General Nurse
Re. O.P#K	Specialise Centre	22/2/2022	3 years	BSN	Male	Indian	General Nurse
Al. S#K	General Hospital	6/4/2022	2 years	BSN	Female	Indian	General Nurse

Table 3.16: Group B
Sub-group Q: Nurses

Participants (Codes)	Hospital	Date	Years of experience	Qualification	Sex	Nationality	Position/Role
Me. U.S#Q	General Hospital	14/72022	21Years	BSN	Female	Indian	Team Leader
Ba. O.T#Q	General Hospital	15/7/2022	3Years	Diploma	Male	Qatari	General Nurse
Ni. I.C#Q	Specialised Centre	21/7/2022	7 Years	BSN	Female	Indian	General Nurse
El. S#Q	General Hospital	3/8/2022	21Years	BSN	Female	Indian	General Nurse
Pe. S#Q	General Hospital	5/8/2022	21Years	BSN	Female	Indian	General Nurse

Dh. I.C#Q	Specialised Centre	10/9/2022	21Years	BSN	Female	Indian	General Nurse
Sa. S.#Q	General Hospital	14/9/2022	21Years	BSN	Female	Indian	General Nurse
Lu. O.G#Q	General Hospital	12/3/2022	16 Years	BSN	Female	Jordanian	General Nurse

Table 3.17: Group B
Sub-group J: Nurses

Participants (Codes)	Hospital	Date	Years of experience	Qualification	Sex	Nationality	Position/Role
Mo.I.C#J	Specialise Centre	28/3/2022	18 Years	BSN	Male	Jordanian	General Nurse
Ta. O.T#J	Specialise Centre	18/7/2022	3 Years	BSN	Male	Jordanian	General Nurse
Hu. S#J	General Hospital	8/2/2023	14 Years	BSN	Female	Jordanian	General Nurse
Ta.E.R#J	General Hospital	9/2/2023	5 Years	MSN	Male	Jordanian	General Nurse
Sa. O.P#J	Specialise Centre	9/4/2022	2 years	BSN	Female	Jordanian	General Nurse

Table 3.18: Group B
Sub-group E: Nurses

Participants (Codes)	Hospital	Date	Years of experience	Qualification	Sex	Nationality	Position/Role
Ab. U.S#E	General Hospital	30/3/2022	18 Years	Diploma	Male	Egyptian	Head Nurse
Ah. S#E	General Hospital	21/4/2022	20 Years	MSN	Male	Egyptian	General Nurse
Th. O.P#E	Specialised Centre	3/5/2022	2 Years	Diploma	Male	Egyptian	General Nurse

3.10. Ethical Aspects

The research must adhere to international standards of research, those standards aim to promote the quality of the research as well as ensure the validity of the research (Qaseem et al., 2012). On the other hand, in healthcare, the ethical standard aims to improve the clinical practice as per the Clinical Practice Guideline (*ibid).* Therefore, considering ethical aspects provides protection for others from harm and protects their right to participate or withdraw from the research (Israel and Hay, 2006). Some situations require researcher judgments and decisions, for example, in terms of the research, the researcher cannot share any information or details about the participants with the organisation management or other participants. Symonds and Gorard (2010) and Cohen, Manion and Morrison (2011) highlighted that sometimes the interviews are sensitive and could generate rich data that requires knowledge and experience. This will lead to understanding individuals' thoughts and emotions as well as private and public lives (Silverman, 2013; Mears 2017). Therefore, it is necessary to obtain ethical approval before performing any interview. Cresswell and Clark (2011) stressed that an ethical violation could occur in any research, regardless of that, the chances increase more in social science research. For example, in social science, researchers might be stereotyping or constructing their interpretation and understanding based on their own ideas or perceptions.

Therefore, the researcher must consider two main aspects in this research, first of all, nothing can be copied. The second thing is maintaining participants' confidentiality, both aspects can be maintained by applying for the University's Ethical approval. Ethical approval provides guidance throughout the research process, it also enhances the researcher's awareness of the relevant ethical aspects, that require a plan to deal with them (Creswell and Poth, 2018). The ethical consideration starts by identifying the participants and the site of the research, till the end of the research and publishing it. Consequently, adequate acknowledgement through references is required for all the accessed sources in the research. Some participants held top administrative positions in the M.O.H. Therefore, the ethical issue has been considered in this research and the confidentiality of the participant information has been maintained by providing an informed consent form and participants' information sheet (see Appendix 3.3).

3.10.1. Informed Consent

A compulsory informed consent form and participants' information sheet were shared through email among the participants prior to the data collection, to keep the participants' and organisations' identities confidential and to improve the participants' understanding of the research. It provides a brief idea about why the research is being conducted, its purpose and the possible outcome. Further, the role of the participants in the research has been explained in the participation sheet. It was ensured that each participant had access to the consent form within 7 to 14 days prior to the interview. Individual participation is purely voluntary in this research and the participants have the right not to play a part in this research. There are no harm or consequences for withdrawing, the participants can withdraw from the research at any time within 12 weeks from the date of participation.

3.10.2. Confidentiality and Anonymity of Research Data

Ensuring confidentiality is important before performing the research to provide comfort for the participants to talk freely without fear of exposure. There is a probability that the participants could be identified directly or indirectly from the outputs of the research. Therefore, the consent form along with the participant's information form was provided to ensure confidentiality as mentioned in the previous section. Therefore, the participants' names and details have been secured and anonymity applied to save the participant's details. In the case of sharing the research findings, participants' details have been protected by using the different anonymous classifications. Furthermore, the data has been pseudonymised, the details of which are in section 3.9.2. (page: 132), and the countries are classified as groups K, Q, E, and J. After finalising the project, the data will still be kept confidential by using the NTU Data Management Plan to save the data from unauthorised access, only the authorised people have the right to access the data when needed.

3.10.3. Data Storage, Management and Archiving

In accordance with the NTU Records Retention Schedule, the transcript for interviews will be retained for 10 years from the date of deposit as per the NTU Data retention policy, this is further explained in section 3.8.1 (page: 124). In addition, the NTU data store and data archive were used to save the records and archive the data. Audio recordings of interviews will be destroyed by the end of the project. Further, for destroying the retained data, the NTU data management guidelines will be followed.

3.11. Validity and Reliability of Data

3.11.1. Data Validity

The qualitative research validity relies on the authenticity of data collection, assessment, and interpretation (Whittemore, Chase and Mandle, 2001). Assessing the accuracy of the assembled data is essential in qualitative research. According to Lincoln and Guba (1988) and Cypress (2017) the word “trustworthiness” refers to different terms namely authenticity, dependability, credibility, confirmability, and transferability. That is also equivalent to reliability and further internal and external validation. In research, the validation process could be used to assess the accuracy of the research findings, by combining qualitative research strategies, alongside having a mutual understanding between the researcher and participants (Creswell and Poth, 2018). It also assesses the realities in the investigated area as well as the participants’ experiences. Therefore, the validation process required integration between the researcher and the research methods with data. It is necessary to provide a solid description of the data’s trustworthiness to ensure that the findings are valid and manageable. The data validation process is important and considered a standard for assessing the structural adequacy and rationale as evidence for asserting the trustworthiness of qualitative research. For data validation, the researcher looks for a piece of evidence for recurring behaviours or attitudes, at the same time considering any adverse evidence that might impact the interpretation. In this research, the participants are mainly nurses and doctors who are related to the field of skin integrity and wound management, hence, all the data will be related to this field. Moreover, for data validation, the researcher seeks more description, interpretation, and evaluation of the findings. Data validation aims to define the trustworthiness of data, by avoiding any misleading or harmful data.

A preliminary assessment was developed to reduce the potential for bias or incomplete data, which would affect the trustworthiness of the interpretation. The trustworthiness of the research is determined by compiling and analysing the sources of data in a complementary manner (Cresswell and Poth, 2018). Each interview was analysed independently so that the researcher’s objectivity would not be impaired, further assessment was applied to the results to avoid misinterpretation of information. Angen (2000) argued that validation is basically known as a researcher’s judgement of the integrity and trustworthiness of the interpretation of research. Thus, it would be challenging for the researcher to validate as the analysis has an element of personal judgment and bias in the interpretation. Hence, in this research, the actual

finding is presented without changes to ensure validity. This helps in developing a comprehensive understanding of the sociological perspectives and requires analysing the data from different sources such as policymakers, hospital directors, nurses and doctors. Hence, this analysis explored opposing views of the research alongside examining the depth and cohesions of each finding. According to Creswell (2014), interview analysis will help to recognise, assess, and explain the differences in the experience of different participants' categories. This also assists in improving the interpretation of data.

3.11.2. Research Reliability

Reliability in qualitative research is strongly associated with the dependability and accuracy of the collected data, as well as managing data. According to Rose and Johnson (2020) and Silverman (2011) reliability can be achieved through trustworthiness in qualitative data. For example, interview questions are built based on a substantial academic foundation, further, the researcher used piloting to ensure that the questions are valid and trustworthy. A data management plan was developed to deal with data efficiently based on the University policy and guidelines. Lincoln and Guba (1988) highlighted four primary criteria to assess the research validation and reliability, this is given in Table 3.19, and secondary criteria are associated with the following: clarity, explicitness, creativity, thoroughness, sensitivity, and congruence.

Table 3.19: Research Validation and Reliability

Criteria	Sort of questions
Credibility	Are the results an accurate interpretation of the participants' meaning?
Authenticity	Are different voices heard?
Criticality	Is there a critical appraisal of all aspects of the research?
Integrity	Are the investigators self-critical?

As adopted from Lincoln and Guba (1988)

Improving the credibility of the research methods and data would increase the validity and reliability of the research (Mercier and Silverman, 2014). Credibility focuses mainly on assessing the accuracy of the findings, which could be achieved by active and prolonged engagement in the field (Korstjens and Moser, 2018). This is maintained by applying verbatim

transcribing, besides using Microsoft Teams recording features, to record and retain the data for analysis and interpretation (Creswell and Tashakkori, 2007; Ritchie et al., 2013). In this research, the researcher maintained the accuracy of the findings by attending constant meetings with supervisors to discuss the data and based on the recommendations the adjustments made. Moreover, reliability in qualitative data is retained by developing codes (Creswell, 2007). Therefore, the researcher used a coded diary to maintain the accuracy and precision of the data.

3.11.2.1 Researcher Reflexivity

The critical reflection of the researchers regarding their role in collecting and analysing data is identified as Reflexivity. It enhances the researcher's awareness of the entire research process. According to Seale and Silverman (1997), reflexivity draws out the theoretical and epistemological stance of the topic, it is a useful approach to determine the researcher's familiarity with the issue.

3.11.2.2 Researchers Positionality

After exploring the professionalisation theory and understanding the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt in the previous chapter, it has been determined that this research can be a useful contribution to the knowledge related to the nursing profession and their role related to skin integrity and wound management. Hence applying qualitative research enables the researcher to explore and understand the issue rather than just answer the research questions, which implies a finite conclusion. The literature review was the passage for understanding the theory of professionalisation, but the real implication of the theory and the research process begins in this chapter. According to Kauppinen (2018), the researcher's positionality involves individual beliefs and thoughts about something. Research is always influenced by several issues, consequently, when the research gets affected by personal opinions against one individual or group this is called bias (Smith and Noble, 2014). The word bias has a very particular meaning in quantitative methods which assume that the world can be controlled, therefore bias can be avoided. On the other hand, in qualitative methods such as in-depth interviews, the researcher looks for diversity and some patterns in the data. For example, if a researcher has some biased thoughts about some ethnic group; these ideas and thoughts that form the beliefs; it can be managed by a reflective process and by trying to avoid personal judgment, or such ideas when forming the beliefs. Instead of making conclusions at the beginning of the research, focus on the research objectives, then rely on the facts and present them the way they are. Another essential element in the research process is

the researcher's knowledge. For example, good communication and interaction with the participants, avoiding judgements, being flexible with the participants, further being humble and polite while talking with the participants. This process includes forming research questions or modifying the questions to be applicable to research changes and needs. It also involves more reading, understanding, interpretation and patience. Therefore, being an insider in the health profession as a nursing leader and quality in-charge develops trust. This also enables to develop some understanding of the culture and norms in Kuwait, Qatar, Jordan, and Egypt, which is a strength of this research. However, the lack of participants in Kuwait and the lack of cooperation from some health personnel give me the feeling that people are considering me as an outsider.

3.12. Summary

The approach of this research is qualitative based on the underlying research assumption and the area of research. Profession and Professionalisation of nursing in relation to skin integrity is a qualitative aspect that can be explored using exploratory research design. Semi-structured in-depth interviews were conducted to generate insight to provide a deeper understanding of the issue. For further understanding, the philosophical perspective has been explored. This was followed by a description of the analysis and presentation of the qualitative data, along with ethical considerations and data validation. In addition, the qualitative data finding is presented in the next chapter.

CHAPTER FOUR

RESEARCH FINDINGS

4.0. Introduction

This chapter presents the findings that emerged throughout the data collection. The finding is presented in the form of themes to be more precise and clearer, in order to enhance the understanding of the issue identified. The chapter includes the presentation of the main themes and sub-themes separately.

4.1. Presenting the Qualitative Data

Illustrative and analytic approaches were both applied collaboratively to present the data. Therefore, thematic analysis was performed following Braun and Clarke (2006). It assists in discovering commonalities in the responses of the participants, following each theme a number of sub-themes have emerged. A total of 32 in-depth semi-structured qualitative interviews have been conducted with participants from Kuwait, Qatar, Jordan, and Egypt. Table 4.1 presents the distribution of these participants between the respective countries. The respondents were divided into groups (A) administrative role and group (B) clinical role (Chapter Three, Section: 3.6.3, page: 112). The participants' responses generated different themes, and those themes were used to help in answering the research questions, Figure 4.1 shows the research question allocated to each theme. In this research thematic map was used as recommended by Braun and Clarke (2006) to explore the relations between the clusters of themes that have been identified in the qualitative interviews as shown in Figure 4.2. Therefore, in this research, three main themes have been identified that were appropriate to enhance understanding of the perspective and aspects identified. However, for a more in-depth understanding, the researcher encapsulates those themes into different sub-themes. Themes names were generated from the data itself, through a detailed analysis of the information included in each theme.

Table 4.1: Distribution of the Participants Among the Countries

No	Country	Classification	Total Participants
1.	Egypt	Head Nurse, general Nurses	3 Participants
2.	Jordan	Nurses team leaders/in-charge, General Nurses	5 participants
3.	Qatar	Head Nurse, Nurses team leaders/in-charge, General Nurses	8 participants
4.	Kuwait	Decision-makers, Nursing Directors, Nurses team leaders/in-charge, General Nurses, Doctors	16 Participants

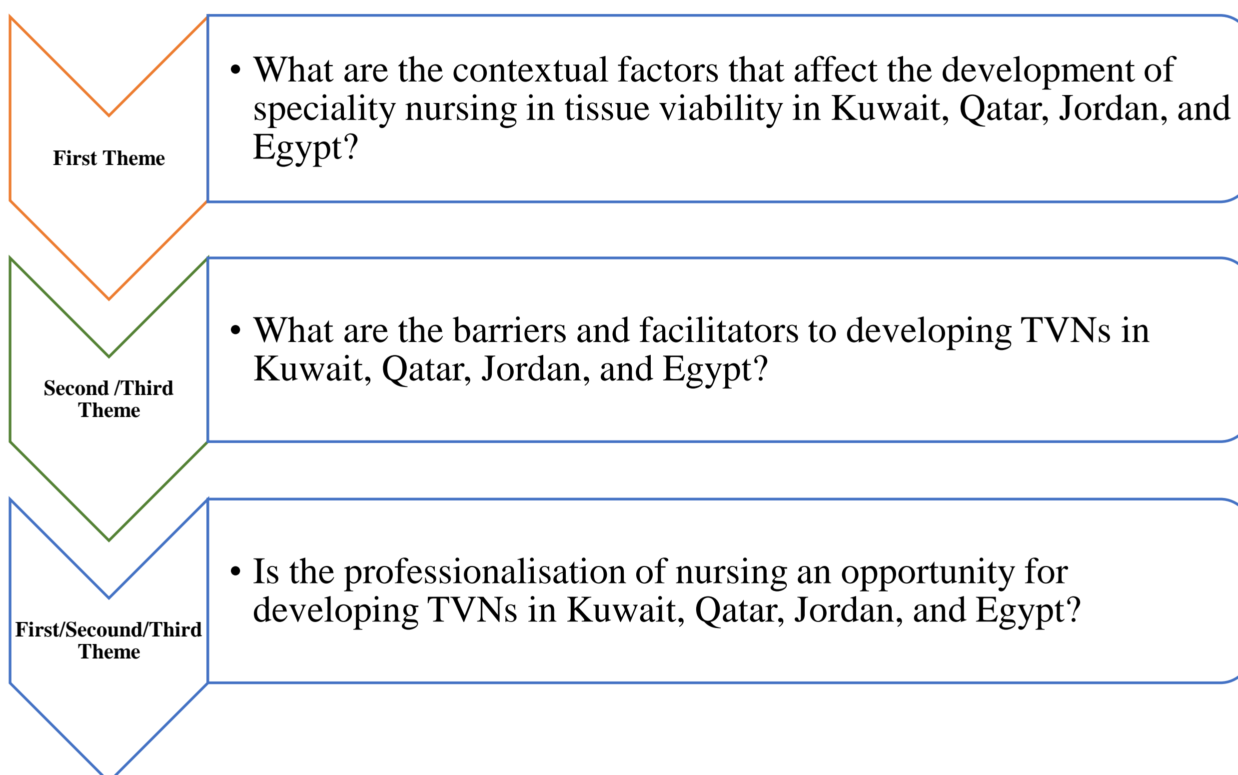


Figure 4.1: Research Question Allocated to Each Theme

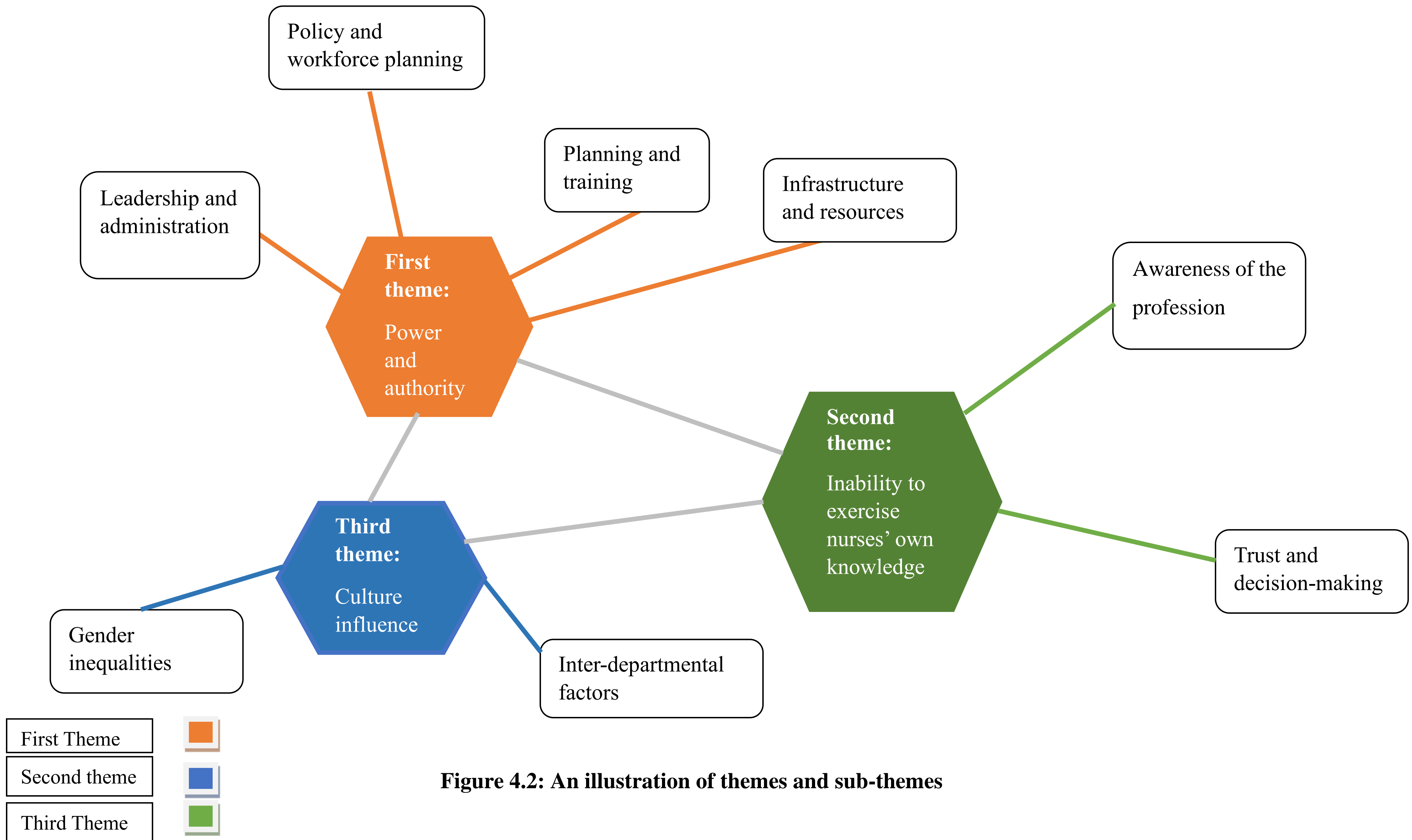


Figure 4.2: An illustration of themes and sub-themes

The outcome of the interview is delivered as themes, each theme focusing on a significant point related to the development of the nursing profession. Identifying the first theme was a little challenging because it required reading and then re-reading to get familiarised with the issue as explained in chapter three (Section 3.9.1, page: 128). In order to enhance the breadth of the information and for more robust data, the emerged themes condensed into three themes. The initial thought or theme focuses on power and authority. The second theme is an inability to exercise nurses' own knowledge. The third theme is culture influences. These themes are distributed according to the country as depicted in Figure 4.3.

Egypt

- **Inability to exercise nurses' own knowledge:** Lack of trust in nursing knowledge.
- **Power and authority:** Financial instability(low salary), Infrastructure and resources
- **Culture influence:** Gender inequalities.

Qatar

- **Inability to exercise nurses' own knowledge:** Lack of trust in nursing knowledge.
- **Power and authority:** High turnover, shortage of the nursing staff
- **Culture influence:** Gender inequalities, Inter-departmental factors

Kuwait

- **Inability to exercise nurses' own knowledge:**Lack of trust in nursing knowledge, lack of awarness in profession
- **Culture influence:** Gender inequalities, Inter-departmental factors
- **Power and authority**: (High turnover) nurses shortage and increase workload.

Jordan

- **Inability to exercise nurses' own knowledge:** Lack of trust in nursing knowledge.
- **Power and authority:** Financial instability(low salary), Infrastructure and resources.
- **Culture influence:** Gender inequalities

Figure 4.3: Developed Themes and Allocation to the Countries

4.2. First Theme: Power and Authority

Nurses play a significant role in providing care to patients, they also have a certain level of power and authority within the healthcare system (McElhaney, 1996). There are nurses in administration positions and there are leaders, however, those leaders do not have the power or the authority to make changes. Apparently, nurses can lead, and despite that, they cannot access their power. The finding illustrates there is a certain level of authority given to nurses to lead. Hence, nurses in leadership positions might have the power, but they lack the authority. For example, nurses' leaders have the power to make decisions related to staffing, scheduling, or delegating certain tasks and responsibilities to other nurses like daily nurses' assignments. However, they are unable to exercise their knowledge in decision-making. Apart from authority

limitations, other challenges interfere with nurses' decisions. The sub-themes that emerged are policy and workforce planning, Leadership and administration, infrastructure and resources and planning and training, these are depicted in Figure 4.4.

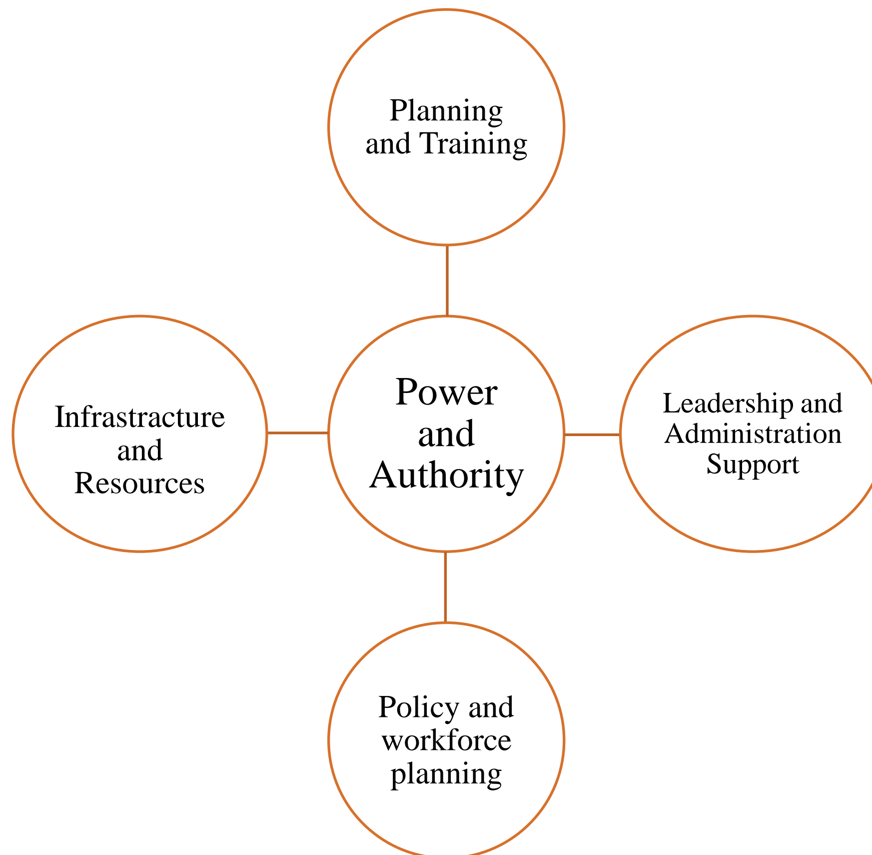


Figure 4.4: Illustration of the Associated Sub-themes to Power and Authority

4.2.1. Policy and Workforce Planning

Policy refers to a set of rules, regulations and guidelines that are formulated by governments to guide actions and decisions (Harris et al., 2020). Policies have significant power in shaping the behaviour of individuals and institutions as explained in the literature review (Section: 2.3.5.2, page: 55). The power of policy lies in its ability to influence individuals' actions. Therefore, the participant's view about the policy was not clear. There is a deeper issue than these policies, the participants were inexpressive and seemed like they were hiding behind their views about policy. Most of the participants were inexpressive about their thoughts and reality. Further, there are mixed views about policy, some considering it positive,

and others overwhelmed by policy. The people's understanding of the policy is far more than regulations or rules, it seems like it is a tool for controlling the staff and increasing the responsibilities where the nurses cannot handle it. Individuals' perceptions and thoughts related to organisation’s regulations and policies for skin care and wound management differ as follows:

From Kuwait:

> ***Hu. P.M#K:*** *Already everything is written in the policy and guidelines, …. We do not want to increase the paperwork and write it again and again, mmm,,,, but we need direct participation from the ministry of health to train those people in Kuwait. No need to spend a lot of money to bring specialised people from outside the country but we need to enhance the nurse's capacity. We need to start training in small groups, not necessarily to use a large scale but at least a small scale like a small centre to implement and evaluate.*

Also,

> ***Ma. N.D#K:*** *First, they must develop a plan and vision related to improving skin care, and then share the plan with all hospitals. Strategic planning is similar to policies and vision, all should be central to the ministry of health. It should not be developed based on individual opinion or interest; the strategies must be developed based on the ministry of health strategy. The strategy for us as a nursing department must be discussed with the nursing directorate through our meetings, especially for improving skin integrity and wound management because we do not have anything related to this in our policy or strategy, the focus is all about safety and quality programmes.*

> ***Ha. A.D#K:*** *The policy is available but needs to be updated for nurses, the available policy needs some work to enhance nurses’ role in the organisation like including staff training in the hospital vision to improve the staff's ability and help to achieve the organisation's goal.*

> ***Fa. N.D#K:*** *Where I was working there were policies and guidelines, it was very effective and helped to improve patient care in general, improve nurses' jobs and*

become more systematic, now nurses are more organised in their work, they label everything according to order in the policies. I worked for more than 30 years and had no policy or guidelines. The policy was coming directly from the nursing directorate. And it was generally about patient care only nothing related to improving skin integrity or wound management.

Ma. N.D#K: *Each hospital has a different policy there is no common goal between the ministry of health and the health organisation.*

Further added:

It is important to make all the policies similar and those policies must be coming directly from the nursing directorate. But if each hospital makes its own policy which is different from other hospitals, Then I do not think we will develop. For the area of skin integrity, there is nothing about it in our policy…….. again, to develop wound management and skin integrity we have to start with the Ministry of Health and Nursing Directorate, they will have to develop the policy and distribute it to all the hospitals and health centres to implement the policy.

There is an obvious fear of external scrutiny and the fear of imposed changes outside the context of their system. Further, the respondents give the implication there is a lack of understanding and confusion about policies. The respondents expressed that there is a conflict between the policies that developed in the MOH and the organisational policies.

Some of the respondents show a lack of command, and less attention to training, from those in higher hierarchical levels, in the nursing profession.

Kh. N.D#K: *I see the policy not being effective; the strategic plan will not be effective even if the mission and vision are all just overloaded for the nurses, and they are very old they need to update them.*

Also, stated,

Kh. N.D#K: *As I said policy, strategic planning and training all increase the workload for nurses, but to develop specialised nurses for skin and wound management first, we have to train them.*

Int.: *Could you explain your answer, I could not understand.*

Kh. N.D#K: *I mean, first the Nursing Directorate must provide staff then they can ask us to follow policies, with the shortage of staff I cannot send staff for training and leave wards to suffer.*

The Following responses from senior team leaders:

No. U.S#K: *The Nursing Directorate wants us to follow policies without considering us.*

Further stated:

No. U.S#K: *Before there was no policy and we were working efficiently and better than now. Now if any problem happens in the shift, they will blame the team leader.*

Ri. U.S#K.: *We have policies and guidelines; we are satisfied with our policy because it helps us to provide better care for the patients. It guides us to do procedures effectively too and this helps to give appropriate care to the patients. Like wound care is an important part of our job because we are a Uro-surgical department. However, the organisation's policies and regulations to some extent might restrict giving accurate care to the patients related to wound management because we focus on the organisation's goals or hospital vision and neglect the area of improving skin conditions or wound care.*

Ti. O.P#K: *MM ,,, I think our policy is good, but doctors are not following it, our job description is to assist doctors, but doctors want us to call them, fill the ink in their stamp, open the door, and hold the examination light while examining the patients. Most of the doctors are not following the policy only nurses, we have to follow.*

She also adds:

> ***Ti. O.P#K:*** *If doctors are not happy, they will transfer nurses to other hospitals for punishment.*

From Qatar:

> ***Sa. S.#Q:*** *Policies not supporting us, if any mistake the matrons will blame us. They will say why you did not follow the policy and they will get angry; they can send us to the medical ward, and you know very busy there and all bedridden.*

> ***Pe. S.#Q****: less staff and we have to study these policies; we cannot focus on our patients' care.*

From Jordan:
In regard to policy, most of the participants were team leaders in Jordan and their views are.

> ***Mo. I.C#J:*** *We are following the accreditation and the policies are up to date. There is a team to review the policies and they will follow up with the staff if everything is suitable for patients and staff.*

> ***Ta. O.T#J****: We have policies and guidelines, but no one is following them.*

> ***Int.:*** *Why not?*

> ***Ta.O.T#J:*** *It is extra work, like you know a lot of documentation, several forms you have to fill, you have to do things in certain ways, these things we cannot follow if we are busy.*

> ***Int.:*** *would you give me an example, please?*

> ***Ta.O.T#J:*** *It is more paperwork and different checklists for rooms and stores we do not have time to do all these forms we start surgery at 7 a.m., and you cannot check in*

the morning we have to wait until all surgeries are finished, at that time we need to have a break and no time left.

Further, a positive view was expressed related to the policy:

Ta. E.R#J: *policy helps to distinguish between your career and another medical profession. Let me tell you, in the policy nurses are allowed to do some jobs, and the policy gives direction for us.*

From Egypt:

Ab.U.S#E: *Also, we have the policies and I think it is good, however, this policy needs to be followed, and needs specific training to make sure that the staff are familiar with it. Without training and following up I do not think the policies will be effective.*

Th.O.P#E: *We do not have a policy, but we are following guidelines.*

Ah.S#E: *Here we do not have policies, and if there are policies no one is implementing them.*

Int.: *Why not implement it?*

Ah.S#E: *Because of work overload and staff shortage, the number that we graduate every year is not enough to cover the shortage of nursing.*

Int.: *Do you think policies increase your work?*

Ah.S#E: *To be honest not all the time, sometimes they are changing the policies frequently and have no time to read the new policies. Like if it is old, I think all of us would follow it. The problem is they are changing it and we do not have time.*

There is a clear mismatch between policy and practice with a strong belief that the policy does not fit but overwhelms people. Further, there is a clash between the MOH policies and organisational policies, which could be an indication there is a conflict of interest in developing these policies, this issue has already been discussed in chapter two (Section: 2.2.1.2, page: 39 and Section: 2.3.4.1, page: 46). For example, healthcare providers may face conflicts of interest when making treatment decisions based on financial incentives, rather than the best interests of the patient. Failure to manage conflicts of interest effectively can lead to legal risks, such as manipulation of official documents and fabrication of the truth regarding patients' care. In healthcare, conflict of interest occurs when a healthcare provider's personal or financial interests or relationships influence or potentially influence their clinical decision, thereby compromising the quality of care delivered to patients. Conflict of interest between doctors and nurses can occur when personal or financial interests clash with their professional obligations or responsibilities, such as doctors might have financial interests in medical devices or drugs that they prescribe for patients. Therefore, they prevent nurses from participating in decision-making. Moreover, the participants are not aware of the policies, and they consider it as an obstacle instead of a tool to improve care. Most of the participants referred to the policies as legal boundaries for nursing. For example, nurses state that decisions must be made by doctors as written in the policy and if the nurses do not follow these policies action will be taken by the management. Therefore, there is a fear of stepping over the boundaries of their current practice, if nurses do something out of these boundaries they will get into trouble with nurses' leaders or hospital management. This also shows two aspects, first related to the perceptions of the profession and power influence in developing this perception. Furthermore, this could also raise an issue about a lack of awareness of the policies or the function of the policies in serving nurse's work. This led to the fact there is ineffective communication between the nursing administration and nurses regarding the policy.

4.2.2. Planning and Training

Training is essential for the professional development of the staff and for developing nursing practice related to wound management and skin integrity, respondents expressed their views about training as follows:

From Jordan:

> ***Mo. I.C#J:*** *I did not receive any training related to wound management, But as I said I received training in other areas.*

> ***Sa. I.C#J:*** *I attended several training courses internal and external, some in other provinces and some in other countries. It helps us to work effectively and improve our skills, but I do not know why they stopped now.*

From Qatar:

> ***Lu. O.G#Q:*** *we are receiving constant training, the training never finished here, and there are different nursing training programmes. This is related to general nursing tasks like dressing and medication administration. Also, there is specific training which is related to the accreditation, safety, or new programme or devise. I do not think these trainings are effective especially when we have a staff shortage, because the administration and staff development units do not consider us as staff. Imagine if someone who has night shifts will sleep or will attend this training, so when you are tired and after your duty how come you will attend these trainings. Now with the technology they are using Microsoft teams to attend the workshop even on your holiday and I do not like it off day, you want to relax or attend a workshop.*

> ***Eli. S#Q:*** *Yes, continuous training, But, the main thing is the shortage of staff so we cannot attend sometimes the training. The workload is very high nowadays, so the shortage of staff, most of the staff are flying to the UK, Ireland and also there is a lot of resignation, and we have a shortage and so the work, the Patient Care plus training all this, it is actually very difficult.*

> ***Me. U.S#Q:*** *I attended several workshops and training programmes, but those workshops were related to general practice, mmmm, it includes wound management but not much.*

From Kuwait:

> ***Hu. P.M#K:*** *It is important to develop the nurse's speciality and improve the training according to the organisation's strategic plan. Important to provide training, training should be for several levels, for example, level 3 is for all nurses to understand how to deal with wounds effectively, and level 2 is for the nurses who are supposed to work in the specialised skin and wound clinic. Level 1 provides intensive courses for nurse instructors to give training for those nurses and use the technology to improve nurses' skills. Like using videos, Microsoft teams and other programs.*

> ***Ha. A.D#K:*** *It could be positive or negative depending on different factors such as continuous training. If the facilities provided such as training, then it will be positive then followed with those staff.*
> *It will be negative if they do not receive appropriate training. Especially because it is a new nursing speciality.*

> ***Fa. N.D#K:*** *Yes, yes, if there is training no need to worry. If we develop strategic planning and training this will support TVNs. Before we had specialised nurses and those nurses took courses in Lebanon related to their speciality. Mmmmmm, that was for the first patch of nursing. But if we have a policy that supports specialised nurses, no one can transfer me from one department to another.*

> ***Kh. N.D#K:*** *Training is not important for the time being, I consider it as overwork for nurses. Now everything needs to be computerised. We have to write nursing notes manually and on the computer already. We have a workload and there is no chance of sending staff for training.*

At the same time, the respondents gave a contradictory statement when asked about including wound care training in the mission and vision of the organisation.

> ***Kh. N.D#K:*** *Yes, for sure, it must be part of the vision and mission, but I see those nurses who attend the workshop or conference, just overloaded for nurses, honestly, most of the nurses will attend a conference or lecture to sleep.*

Sa.O.P#K: *Training is important, but I did not receive training for wound management. I was assigned to a dressing room with another nurse to teach me for 1 month after that I learned how to do dressing alone. Actually, training is important to know the changes and help us do the work wisely but outside the organisation, I did not receive training, but it is important.*

Nu. U.S#K: *I have received training from the Staff Development Unit, sometimes they send us to receive training from SPTD in the nursing directorate or external training but not all training is about wound management. Also, in the ward usually, we have a class every Saturday about dressing with a demonstration.*

An ambivalent attitude was noticed in different instances, for example, some of the answers supported skin integrity, but in reality, the participants' responses clearly stated that developing TVNs is overwhelming to consider during the pandemic. However, the interview took place in November 2021, after the pandemic period. Also, lack of awareness in training where the courses or conferences are seen as a time for nurses to sleep and relax rather than develop and progress. Another aspect related to technologies and digitalisation is seen as a burden to deflect away from direct patient care. Moreover, three respondents working in Kuwait at different outpatient departments expressed their desire to improve their skills and practices as a nurse, where there is no organisational support for staff development and training. There is less exposure to external training, apart from the one held in the organisation. Most of the nurses who work in wards and critical departments such as operation theatre and emergency departments receive training frequently. The provision of training and courses was planned according to the department's priority and personal preferences. For example, people who are working in critical departments such as operation theatre, intensive care units, or regular wards receive training regularly. In contrast, the area of training is neglected in clinics or outpatient departments. However, training is a basic nurse's right and does not correlate with changed roles, for instance, the training related to wound management and skin care is similar for all nurses.

4.2.3. Leadership and Administration

Developing wound specialist nurses requires leadership support, to guide and direct individuals and to ensure there will be no resistance to the new changes in their role (Chapter Two, Section: 2.4, page: 57). Lack of administrative support can have negative outcomes on an organisation or a team. When administrative support is lacking, individuals may feel undervalued and unsupported, as a result, might resist any changes, or lead to disengagement

and turnover. Individuals may lack access to the information or resources they need to make informed decisions, which can lead to mistakes or poor choices.
In Kuwait, the following participants stated:

> ***Fa. N.D#K:*** *For decision making, we nurses cannot make any decision individually, if any mistake occurs no one is going to support nurses because we do not have regulators, we have a nursing association, and this association has no right to make the policy and regulation in favour of nurses. The nursing association has no power to develop a policy or to protect nurses, other countries have the right to talk because they have a nursing union.*

> ***Kh. N.D#K:*** *nurses have the knowledge, yes, we have, but not all of them. Also, we have to make sure that the nurses are not interfering doctor's job otherwise they will be sent to the legal affairs.*

> ***Ti. O.P#K:*** *No support from administrations. If doctors are not happy, they will transfer nurses to other hospitals as a punishment.*

> ***No. U.S#K:*** *It is okay to help us with what to do and what to avoid, mmmm,,,, I think needs to be revised… mmm, make it simple and easy to understand. Not too many rules. We need something efficient for nurses. Before there was no policy and we are working efficiently and better than now. Now if any problem happens in the shift, they will blame the team leader. I have to do rounds with the doctors, write special assignments for nurses, send staff to the pharmacy and medical store, sit at the counter, and write patient 24-hour reports... too much work for the team leader. It is good to have a policy to improve care but should be updated, also hospital vision and mission must be updated.*

Further, he added,

> ***No. U.S#K:*** *Sometimes people go up and they do not know about nursing, they do not have experience in working with patients or doctors. The higher manager. must be more understanding of the staff, there is no support for nurses. So, they are simply giving*

orders. This is especially from the Nursing Directorate; they want us to follow policies without considering us.

From Jordan:

Ta. O.T#J: *Lack of support from nursing administration, always supporting doctors if any complaints against nurses.*

Ta. E.R#J: *In general, the specialised nurses are more skilful in their area of speciality. I have an example, one nurse with 20 years of experience in the cardiac department, had opinions regarding a patient's heart problem, and he was arguing with the doctor about malpractice. In the end, the administration supported the nurse. This is only an example where I saw a nurse in a situation arguing with a doctor and he got support.*

In Qatar similar issue was expressed

Sa. S.#Q: *Policies not supporting us, if any mistake, the matrons will blame us. They will say why you did not follow the policy and they will get angry; they can send us to the medical ward, and you know very busy there and all bedridden.*

From Egypt:

Ab.U.S#E: *Lack of organisational support and system malfunction. Sometimes, the staff development unit focuses on training the specialised nurse and neglects the general nurse's training.*

Int: *What do you mean by system malfunction?*

Ab.U.S#E: *I mean the way of controlling the system like nepotism, staff promotion based on management preferences not based on qualification.*

Two participants only explicitly reference their 'career' and the underlying principle for being in the nursing profession. Some of the responses were not clear and some of the

participants were not able to explicitly express their feelings or share information. This could be fear of the consequences or organisational limitations. Some participants' comment implies that they prefer developing a nursing speciality in the skin, but the reasons or thoughts were unclear. The respondents show that organisational policies and rules are highly confidential, and participants were not expressive about it. Some imprecise information and responses cannot be guaranteed, some nurses assume that the nursing speciality will overall increase their work and some nurses were reluctant to share their thoughts, which reveals organisational behaviour and culture, (Chapter Two, Section: 2.3.5.1.1, page: 53 and Section: 2.3.5.1.2, page: 54). Moreover, being at the top of the nursing administration hierarchy does not make a difference in changing the perception of the profession. The finding shows a lack of administration support which is reflected in the way of dealing with the nurses to avoid nursing professional development and progress. Further, staff promotions and professional development opportunities are influenced by bureaucratic issues (Chapter Two, Section: 2.3.4.2, page: 48). Therefore, changing the perception of the nursing profession is fundamental to making changes in their professional practice and improving the area of skin integrity and wound management. This will be possible by focusing on the capacity of nursing knowledge and whether this knowledge can be transferred into their practice.

4.2.4. Infrastructure and Resources

Without sufficient infrastructure, individuals and communities may lack basic necessities such as reliable technology. This can have a significant impact on the quality of life, as well as health and well-being. Hence, without access to the necessary resources, individuals may struggle to provide efficient wound care.

From Jordan:

> ***Mo. I.C#J:*** *I think we need to invest in different nursing infrastructures that will help to encourage all nurses to be specialised and to have the voice same as doctors.*

> ***Sa. I.C#J:*** *I think policies are not implemented properly in my departments; I do not know about the rest of the other departments. We have updated policies and protocols but sometimes we do not follow them because of work circumstances, like being busy or lack of items you can say no dressing material like a specific dressing set, we are*

using a mouth care set to do dressing most of the time, sometimes using gauze instead of cotton to clean the wound and patients do not like it.

Similarly, in Kuwait:

Hu. P.M#K: *We need the resources to develop new nurses' speciality I do not mean financial resources, but I mean to provide the time, places, and instructors.*

Ha. A.D#K: *We do not have the infrastructure that supports nurses to develop. Also, we do not have effective training programmes. MMMM ,,,, regarding skin and wound management we do not have awareness, and as mentioned the lack of infrastructure restrains the nursing profession from developing as a speciality.*

Ri. O.P#K: *The policy is effective, but for the time being, we cannot follow it, if they need the staff to follow the policies, they have to provide resources, such as staff, time, and items and machines. For our benefit we need policies, but to follow the policy the administration must provide resources. We have items not required in the outpatients' department like devices to check creatinine level and for dressing not everything there.*

From Egypt:

Ah. S#K: *Lack of infrastructure, we do not have enough hospitals or health centres, and old buildings are in bad condition, some are from King Farouq's time.*

Another participant highlighted the issue of system malfunction as follows:

Ab. U.S#K: *Sometimes the computer shuts down unexpectedly, and we need a new generator to avoid a shutdown in the electricity, also sometimes* we cannot access *patient records because of a glitch in software.*

Lack of resources and system malfunction could be the consequences of the financial stability of the country. For example, the reduction of funding and resources could constrain the budget for essential medical equipment and supplies, then compromise the quality of the care provided to patients. With limited resources, health organisations prioritise their services and reduce access to essential treatments. In the case of wound management, a lack of infrastructure could hinder the development of TVNs in Kuwait, Qatar, Jordan and Egypt. It could also affect nursing training related to wound management. Further, patients will suffer due to a lack of essential resources such as materials and equipment for wound care. As a result, prolonged stay in the hospital due to wound infection and delay in healing wounds. Therefore, this will impact the performance of nurses which can compromise the quality of care provided to patients. Health organisations need to develop strategies to address the lack of resources and maintain financial stability to improve wound management.

4.3. Second Theme: Inability to Exercise Nurses' own Knowledge

Nurses have specialised knowledge and training related to patient care as Macheridis and Paulsson (2019) highlighted that the profession gives individuals the power to make effective decisions. Likewise, Bourgault and Parent (2008) and Hampton et al. (2009) highlighted the professional knowledge and skills related to the career are transferred to principles that guide employees in their decisions. As such, nurses have the power to make clinical decisions based on their experience (Coombs, 2003). This aspect has been discussed in chapter two (Section: 2.3.5, pages: 49-50). Despite that, the respondents were unable to make a decision regarding patient care.

One participant from Egypt and another from Jordan emphasised that nurses could have more knowledge than some doctors.

> ***Ah. S#E:*** *Yeah, we have the knowledge and experience, I think we have more knowledge than doctors for wound management because we see this every day. According to our experience, we deal with patients directly. This makes us decide better than other professionals.*

In contrast, one senior nurse stated:

> ***Ab. S#E:*** *The doctor must be taking the decisions, not the nurse. Being a specialised nurse does not mean replacing the doctor's decisions.*

Another participant stated,

> ***Th. O.P#E:*** *We have the knowledge, and we can decide if a doctor is not available during night shifts, but our decision is not better than doctors. They study more than us, I think their knowledge is more than nurses.*

From Jordan:

> ***Sa. I.C#J****: I will clean the wound, and if required I will do the suture by myself, it is part of our job. Why wait for the doctors if I knew how to save patients' live. However, some doctors do not like us to interfere, they get angry but not all doctors.*

> ***Ta. E.R#J:*** *I think any nursing speciality will improve nurses' decisions. One nurse in the Cath Lab. had an argument with a doctor. In the end, the doctor realised the nurse was right in his decision. Some doctors accept nurses' decisions, especially those nurses who have experience. But not all doctors like that.*

> ***Hu. S#J****: Experience affects a lot in decisions because my experience in the same department for 9 years helped me to understand the system properly, the doctors and medical teams all know me, and if any patients have complications I can act quickly and make decisions. Not a better decision than other professions, but I told you a doctor has knowledge. I cannot say we nurses have better knowledge than doctors. His decision differs from my decision, but we both can decide.*

From Kuwait:

The following respondents believe that nurses can decide effectively regarding wound management.

Hu. P.M#K: *I am certain that health care providers if they have a speciality in a specific area will improve the services by managing the patients with skin problems, this also will reduce the work for other nurses.*

Sa. O.P#K*: I think we have the knowledge, and we can do good in our work, yeah, I think we can manage. We are able to do that.*

Ti. O.P#K: *Yes of course, we have the knowledge, we are the ones doing the dressing for patients based on the doctor's order. We can know if the patients have wound infection, or clean wounds but we cannot decide on the dressing type without doctors seeing the patient.*

Int: *Why?*

Ti. O.P#K: *Because the policy does not allow us to make decisions, the decisions are for doctors only.*

Ri. O.P#K*: Yes, we have the knowledge and the ability to decide, but we cannot decide, the decision is for doctors only. Actually, doctors and other health providers will not listen to us, but we have the ability to make decisions. It is part of our job to make decisions and solve problems.*

Ri. U.S#K: *Doctors are the ones who instruct us by writing in patients' files their orders then we will follow the order.*

Further, she stated:

Ri. U.S#K*: As nurses counsel, we are supposed to do certain jobs and according to that, we have a point of view. But the doctors are the ones taking the decision, we are just given the care.*

Nu. U.S#K: *Nurses have the experience, they have the skills, they have knowledge from their studies, also, they have working experience, we are equal, both have the*

knowledge, but we have different jobs. We have the knowledge, but we are not better than doctors, we are working with the doctors as a partner. We have enough knowledge, but we are connected to doctors, our decisions must be linked to each other. We are working as a team.

Int: *What do you mean by that?*

Nu. U.S#K: *I mean our decision must be similar to the doctor's decision, like if the doctor said something we must follow.*

Th. U.S#K: *Our knowledge developed from attending different workshops and classes related to patient care. We can teach other staff about skin care,,,, mmmmm,,, yeah but we cannot make better decisions about wound management than doctors. Doctors have better knowledge about wounds, they only have the right to write in patient files. Nurses only have the right to follow what is written in the file prescription. That's it.*

From Qatar also:

Ba. O.T#Q: *No no, the doctor can decide better according to his years of experience and study, like I have studied for 2.5 years, and my knowledge cannot be more than doctors.*

El. S#Q*: There are so many competent people there. They are qualified and have knowledge and training so they can make decisions based on their knowledge, we can make decisions, but it is not worth it, because we have less salary and then if we make wrong decisions more headaches. Matron will get angry, the director then the doctors will shout.*

This illustrates that there is less support from the nursing administration (as illustrated in Section: 4.2.3, page: 157), as well as less value from doctors to nurses.

Lu. O.G.#Q also stated:

> *Yes, we have knowledge, but we cannot, and we are not allowed to take any decision without a doctor's order, really, we struggle a lot every day we have problems with doctors they are not doing their job for patients, and we cannot keep quiet we try to contact doctors, but they do not respond*
>
> ***Int:*** *Why not allowed?*
>
> ***Lu. O.G#Q****: In the written policy we have to follow the doctor's decisions and orders, like that we have to obey.*
>
> ***Pe. S#Q:*** *No, because each one has a section to do related to that decision, if I am a nurse I have some responsibilities, I can take decisions based on my responsibility and our policy, I cannot go on doctors' things, I cannot take the decisions, so for each person it is like that way.*

The findings clearly show that nurses have limitations of scope because they have little influence in decisions about patient care due to organisation regulations or policy. For example, nurses follow doctors' notes without a discussion. Further, most of the participants believed that nurses have the required knowledge so they can be involved in decision-making and improving care. However, they express that it is difficult to participate in the patient care plan due to work limitations or lack of trust in themselves. Some of the respondents stated that doctors only produce knowledge and one of the respondents expressed that experience and skills do not matter in the outpatient department. Even nurses have the knowledge but still, they believe that nurses and doctors must make similar decisions. Given the implication, that nurses are not involved in decision-making, which is as important as knowledge and training for professional development. The profession must enable nurses to engage and deliver their thoughts regarding the care provided.

From Jordan:

> ***Ta. O.T#J:*** *Some doctors accept nurses' decisions, especially those nurses who have experience. But not all doctors like that.*

Apart from knowledge, experience is important for making decisions.

Further stated:

> ***Sa. I.C#J:*** *Some nurses can make better decisions than doctors because we are the ones staying with patients 24 hrs, and we have each shift handover, I think this allows us to decide better than doctors. As I told you this depends on the nurse's ability.*

From Egypt:

> ***Ah.S#E:*** *I think we have more knowledge than doctors for wound management because we see this every day.*

From Kuwait:

> ***Sa. O.P#K:*** *If we want to make a decision ourselves, we must have that knowledge. For example, I can give a loading dose for an MI patient, but we need to know what MI is, we need to read the ECG. We need to know how to read the ECG while taking the ECG.*

Knowledge is a significant element of the profession; however, the following respondent has different views.

> ***Ti. O.P#K:*** *Does not matter what your skills and experience, mainly we need to assist doctors in the clinic. Some Arabic words we need to learn to communicate with patients. Here we cannot make any decision usually, nursing supervisors decide everything.*

Different perspectives have been explored in the interviews such as knowledge deficit, and misperception about the nursing profession by nurses themselves, some nurses underestimate their knowledge and skills. Lack of belief in their ability, skills, and knowledge. Few participants believed in their knowledge and their ability to make a difference. Despite that, the majority believes in terms of knowledge that doctors have more knowledge than them. This theme is divided into two sub-themes as illustrated in Figure: 4.5.

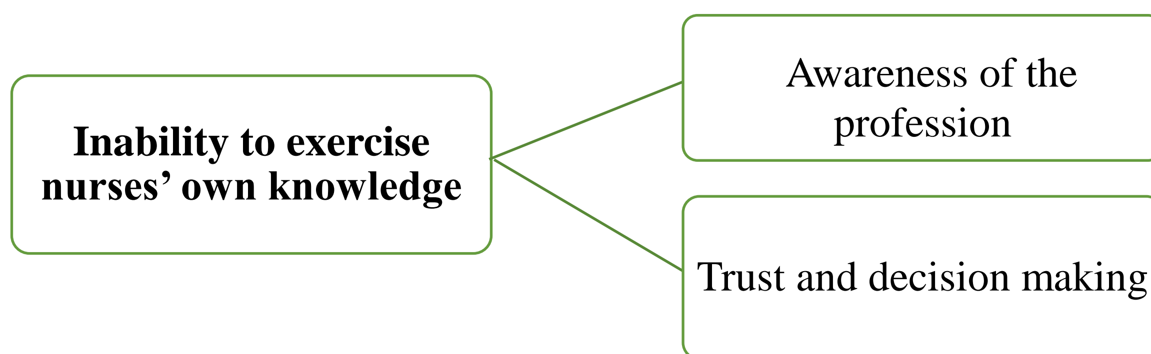


Figure 4.5: Inability to Exercise Nurses' own Knowledge Sub-themes

4.3.1. Awareness of the Profession

Three participants presumed that the specialised nurses would not bring any special knowledge in the area of skin and wound care. They referred to their daily practice as general nurses' which is related to assessing patients' skin and doing wound dressing. Another issue emerged that the criteria for being a good nurse is assessed by having charisma. This means the definition of the profession for them is just based on the ability to talk, with clear negligence to other aspects of professional development which focus on knowledge and training.

> ***Ha. A.D#K:*** *MMMM,,,, regarding skin and wound management we do not have awareness.*

> ***Kh. N.D#K:*** *According to me, nurses are knowledgeable and have the ability to work in any situation but still, this could vary from one nurse to another, depending on the nurse's character and charisma.*

There is a misconception and lack of knowledge about the role of specialised nurses in skin and wound management. Most of the participants believed that the role of the specialised nurses is limited to dressing only. However, doing a wound dressing is a routine part of fundamental care, further, specialising in tissue viability is about assessment, diagnostics, and planning care interdisciplinary and treatment plans for patients, not about doing a dressing only (Chapter Two, Section: 2.6, page: 60). Wound management and skin integrity is one of the

main cornerstones of the fundamentals of care in the UK (Raepsaet et al., 2022.). However, the respondents from Kuwait, Qatar, Jordan, and Egypt revealed that skin is not considered a quality indicator. Though, at the international level skin care is a main quality indicator. Participants also acknowledge the importance of policy in improving the quality of care without any specific references to the area of skin integrity. Therefore, these interviews illustrated that there is a lack of knowledge and awareness of the role of TVNs in skin and wound care. This deficiency in the role of the nurses leads to other aspects such as unsupportive thoughts toward the TVNs in skin and wounds. Some consider this speciality as a hurdle to providing efficient care during emergencies, especially after the pandemic.

4.3.2. Trust and Decision Making

Most of the participants (nurses) believed that their duty is to assist the doctor. Further, they are referring to doctors' notes as a doctor's orders, which possibly reflects the way the nurses idealise doctors or see doctors better than them academically and clinically. Clearly, there are strong issues of supremacy and gender inequalities, for instance, most nurses refer "he" to the doctor. This highlights an issue related to the role of nurses and doctors, where doctors are seen as a prominent profession and superior to the nursing profession. This also reflects the issues of domination (Chapter Two Section: 2.3.5.1, pages: 51-52). Hence, it is important to be sensible in asking questions to explore the legal boundaries of the nursing profession and what would need to be done in order to develop the nurse's role.

From Kuwait:

Kh. N.D#K: *Nurses have the knowledge, yes, we have, but not all of them.*

Ri. U.S#K: *I think the lack of trust is the main issue we face here, like anything I will tell to patients, they will not believe me, patients just listen to doctors. Sometimes the patients do not accept the fact they are facing. Like: not accepting their diagnosis so they will get nervous, sometimes they expect to receive more care and because of the shortage, we cannot meet patient expectations. Like If I say you have to walk or to avoid eating this will keep doing this unless doctors will talk to them.*

The previous points could have a different stance, first stances there is uncertainty in some nurses' knowledge. That could also be referred to lack of trust in nurses' knowledge. On the other hand, another point emerged from a doctor as follows:

> ***Wa. D#K:*** *Yes, nurses have the knowledge, but I did not see any nurse discussing the treatment plan with me, whatever we say as a doctor they are following.*

> ***Hu. P.M#K:*** *mm…. Nurses have the capabilities; however, they do not have the ability to decide for several reasons. Doctors are the ones responsible for making the decisions and they are not accepting nursing participation in decision-making.*

Further, he added:

> ***Hu. P.M#K:*** *Mmm, also we cannot deny that some nurses from some countries are not arguing with doctors and cannot say right or wrong. Regardless of nationality, I have never seen any nurse confront a doctor related to patient care. Nurses might argue with doctors related to their job description if the doctor asks the nurse to do something that is not part of the nurse's responsibilities. I never heard or seen a nurse argue with a doctor regarding a patient's medical issue.*

Doctors are always seen as dominant and usually considered superior to nurses; hence, this makes nurses afraid to discuss with doctors regarding patients' care. The finding shows that nurses are not able to express their thoughts about patients' care or about any aspect related to the organisation. Doctors' behaviour toward nurses will never change unless nurses stand up for themselves. It is important to empower nurses and give them more control related to their work, such as involving them in decision-making processes, recognising their contributions to patient care and providing training and professional development opportunities such as education and internal and external workshops related to professional development. However, the findings reveal issues of domination and supremacy in the organisation. Doctors are the ones controlling the knowledge, hence, not accepting nurses' involvement in decision-making. It is clear there is a decolonising of the professional knowledge and deskilling of nurses. The respondents revealed there is professional domination, in which nurses are considered as doctor assistants or tools. To date in Kuwait, Qatar, Jordan, and Egypt; nurses are considered as doctor

assistants as revealed in the literature review (Chapter Two, Section: 2.10.4, page: 74). Further, most of the participants expressed that the policy stated to follow doctor instructions which reflect the issues of dominations or rigid culture in Kuwait, Qatar, Jordan, and Egypt. Furthermore, the fear of the policy and regulation could be the reason for nursing disengagement in decision-making. This can be the outcome of organisational culture (Chapter Two, Section: 2.3.5.1.2, page: 54). This leads to the third theme related to cultural influences.

4.4. Third Theme: Culture Influence

Culture plays a critical role in shaping the values, beliefs, and behaviours of individuals in a health organisation (Yu and Pirnazarov, 2020). Culture can influence how individuals communicate in a health organisation. For example, in some cultures, individuals may be more reserved and less likely to speak up or ask questions, this can impact communication and lead to misunderstandings. It can also influence decision-making in a health organisation. For example, some cultures may prioritise group consensus and collaboration, while others may value individual decision-making and autonomy. Culture can also impact patient care in a health organisation. For example, healthcare providers may need to take into account cultural beliefs and practices when developing treatment plans or providing care as illustrated in chapter one (Section: 1.3, page: 8). In addition, culture can also shape the values and priorities of a health organisation (Chapter three, Section: 2.3.5.1.1, page: 53; Section: 2.3.5.1.2, page: 54). For example, some organisations may prioritise patient-centred care, while others may prioritise efficiency and cost-effectiveness.

> ***Hu. P.M#K:*** *Still, doctors are the ones who decide for patients, they do not have the culture to accept nurses' involvement in the patient's care plan. No empowerment for the medical teams. They do not acknowledge the presence of other medical teams. In addition, still, nurses need to have more knowledge and skills to develop as a speciality.*
>
> *Doctors consider nurses as a tool to implement their orders.*
>
> *The issue is that nurses are developing their care plan individually which is wrong, the care plan must be discussed with the medical team specifically in complicated cases and the head of the team must be a doctor. The team should meet together to discuss the patient's case. What we need to achieve and how to achieve it. Then accordingly*

they will write the plan and each member of the team must do his or her part in the plan. The issue is that mmmmm,,,,,, senior doctors usually not accepting any involvement from any member of the medical team, even other doctors. Usually, they think they are right in their decision, and they do not even accept radiology or pharmacist suggestions sometimes. So, I do not think they will accept nurses to be involved in the decision, of course, because of cultural issues.

We need to explain to them that they are the leaders of the team. This team has responsibilities and goals that need to be achieved. Being a leader does not give them the privilege to only give orders without listening to other team members.

According to history doctors usually like to think they are always right and do not accept nursing involvement in decision-making or care plans.

Mmm, also we cannot deny that some nurses from some countries are not arguing with doctors and cannot say right or wrong. Regardless of nationality, I have never seen any nurse confront a doctor related to patient care. Nurses might argue with doctors related to their job description if the doctor asks the nurse to do something that is not part of the nurse's responsibilities. I never heard or seen a nurse argue with a doctor regarding a patient's medical issue.

We need to change the culture first because I think mainly the old nurses will face resistance from them, it is difficult to deal with them and it would be difficult to change old nurses' knowledge. Mmm… I think it will be difficult to enhance those nurses' knowledge.

Other respondents highlighted similar issues,

Ha. A.D#K: *It is difficult to accept nursing as a profession due to cultural perspectives and community perceptions. Apart from this, the strategies and policies need to be amended to help the new nursing speciality. Difficulty in accepting the change, the Ministry of Health needs to make the policy or update the policy and job descriptions. For example, if the Ministry of Health develops a new speciality needs to be added. Sometimes nurses as a profession people do not prefer, due to cultural perspective. Having a different shift and dealing with men, is against our conservative culture. But, the area of skin and wound management, I think is suitable for a female to work in.*

Wa. D#K: *I did not see any nurse discussing the treatment plan with me, whatever we say as a doctor they are following.*

Ri. S#K: *As a female working in the male department, patients do not accept females working with males, especially in urology cases. This changed my role from being a bedside nurse to a team leader. My role as a team leader is to manage the nursing counter, doctors' rounds and follow the staff. You know here male patients want male nurses only especially in the urology department because of cultural factors and females also prefer female nurses only to give them care.*

Th. U.S#K: *Cultural differences affect our role as a nurse, the uniform and hair style. Also, night shift with female staff, in India female nurses can do everything for male patients but in Kuwait female nurses are not allowed to do everything only they stay on the counter or prepare medication for male patients. It is difficult to manage work with females on the night shift.*

Re. O.P#K: *Working in the Gulf was initially a little challenging, you know these things like in the break we cannot sit in the same room with female nurses. Actually, understanding the culture was a little challenging for me but then everything was fine.*
Ti. O.P#K: *So many patients come with wound infections because not following our instructions, we observed that patients come with infections using different herbs on wounds and we informed doctors about this. Patients not listening to us just listening to doctors.*

From Jordan:

Mo. I.C#J: *There are no cultural issues. The nursing profession is the best job at this time, especially after COVID. It is a good opportunity for nurses to go abroad and work.*

Ta. E.R#J: *For wound management and skin integrity I do not think there is an issue related to community perception, but in general, the community perception and culture*

do not accept nursing as a good profession. People here do not value us. I worked in Australia with more value for nurses and respect, not like in the Middle East.

Path dependency constraints future choices and decision-making (Chapter Two, Section: 2.3.1, page: 40). For example, path dependency can occur when nurses continue to follow an old medicine protocol, even when there is evidence to suggest that a new approach would be more beneficial. Also, when organisational structure becomes rigid and resistant to change, making it difficult for new ideas or approaches to be implemented, this is described as institutional inertia (Angeles, Ngo and Greig, 2021). Similarly, when nurses follow old policy, even if it becomes outdated or insufficient. Hence, leading to resistance to any change related to their practice. Consequently, path dependency can have negative consequences for healthcare organisations, as it can lead to inefficiencies and lower quality care. Therefore, it is useful to understand the persistence of certain systems or practices, as well as the challenges that may arise when attempting to change them. It highlights the importance of understanding how past decisions and actions can shape current practices. Hence, from cultural influence, two sub-themes emerged as depicted in Figure 4.6. In order to develop TVNs in Kuwait, Qatar, Jordan and Egypt, healthcare providers and nurses need to be open to new ideas and approaches and willing to adapt to changes in their role to improve the patient's care, particularly related to skin and wound management.

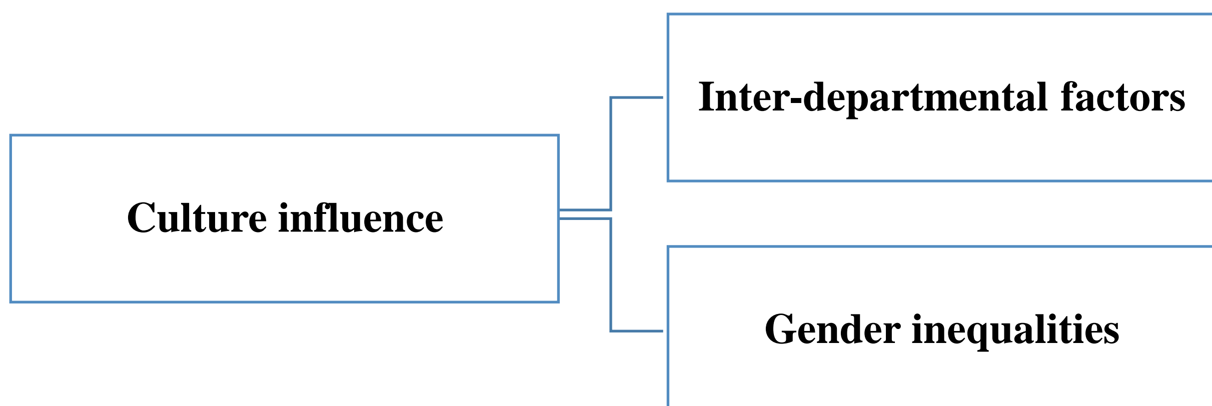


Figure 4.6: Culture Influences Sub-Themes

4.4.1. Inter-departmental Factors

Inter-departmental factors play a significant role in shaping organisational behaviour as illustrated in chapter two (Section: 2.3.5.1.1, page: 53). These factors refer to the interactions and relationships between different departments in the organisation (Menon, Jaworski and Kohli, 1997). For example, effective communication between departments is essential for an organisation's smooth functioning. However, if there is a lack of communication or miscommunication between departments, it can lead to delays, misunderstandings, and conflict, which will adversely affect the patient's care. Departments often need to share resources such as equipment, materials, or personnel like nurses to help in work. Therefore, if one department is not able to manage the work alone due to staff or item shortages, other departments must be willing to help. Allocation of the resources and distributing the staff equally must be part of organisation planning and it includes staff training and development opportunities. Besides, the culture of an organisation could affect how departments interact with each other. For example, a culture of competition can create conflicts between departments, while a culture of collaboration can encourage cooperation and teamwork. In this context, it is important to understand organisational behaviour and how this could impact nurses' performance, especially when developing a new speciality in wound and skin integrity. In social science, it is important to understand individual behaviour, how individuals and groups interact within organisations, and overall, how organisations are functioning. Individuals' behaviour could vary from one to another, which makes it challenging to deal with all employees similarly. Some employees could be very active and skilful related to their duties; however, they could have some issues such as being cautious or having difficulties in expressing or sharing some information with colleagues related to patient care.

The following participants expressed their thoughts as follows:

> ***Wa. D#K:*** *There is a lack of training and no teamwork between the medical team. For specialising nurses, we cannot transfer them from one department to another. Sometimes nursing leaders rotate the staff from specialised areas to clinics based on favouritism. At least, better to keep the specialised nurses to be Kuwaiti nationals to avoid turnover.*

Ti. O.P#K: *No cooperation from other departments, no support from nursing supervisors. If we are busy and asking for help, they will not send help for us.*

Ri. O.P#K: *Sometimes staff are not cooperative. If I ask for help from other departments no one will come, not all the time but sometimes the matron does not send help to us. We have to stay without a break till 2 o'clock to manage everything.*

From Qatar:

Pe. S#Q: *Some departments were taking only from our department neglecting other departments.*

Int: *Who is deciding to send help from your department?*

Pe. S#Q: *Sometimes matrons do a rotation for the staff or take for help, all this leads to staff shortage.*

An important aspect has been raised by the participants about socialisation and social skills, which are believed to be the most significant elements for the healthcare provider (Hargie, Saunders and Dickson, 1994), especially for nurses and doctors (Clark, 1997). However, there is an issue about the implications of changing roles leading to conflict. Therefore, social skills must be implemented efficiently to avoid conflicts with the medical teams. Further, culture is seen to be framed in a conflict framework or who can win an argument and score points. For example, conflicts between nurses and doctors regarding patient care. Also, the perception of conflict as being the way to make changes, for example, the conflict between health professionals regarding health services could be the main reason for the change. Each profession considers their profession more significant than others in perceiving knowledge and skills, to get the privilege of making the decisions. On the contrary, the nursing profession is considered a weak part where they usually do not stand for their rights. Therefore, inter-departmental factors could affect the overall performance and effectiveness of the organisation and could impact organisational behaviour.

4.4.2. Gender Inequalities

From Kuwait:

> ***Al.. S#K:*** *You know, whenever you are busy and you cannot attend one call, you know more than one task at a time. And if you tell doctors to wait for some time, they treat you like anything. I had experiences where I was treated, like mmm, very bad especially because I am a female.*

From Jordan:

> ***H.a. S#J:*** *Generally, our salaries in Jordan is low. I am doing 2 shifts daily, one in the government sector morning shift and one in the private sector. Our salary is not enough, and it is less than men, also men take government allowance more than females.*

The culture and societal influence are very important, especially in Middle Eastern countries such as Kuwait, Qatar, Jordan, and Egypt. Culture has a significant impact on the nursing profession. Therefore, nurses must provide care to individuals from diverse cultural backgrounds in conservative countries. It is important to understand these cultural values, beliefs, and practices in order to develop the profession. Nurses are bound to understand tradition and culture in Kuwait, Qatar, Jordan, and Egypt; changing the nurse's role from one country to another can affect nursing practice. For example, male nurses cannot work in female wards. Culture can also influence the physical appearance, working arrangement, department set-up, communication protocols, and professional behaviour. Culture can also impact communication styles, so it is essential to communicate effectively with patients, their families and other healthcare professionals. Apart from culture, gender inequalities can play a significant role in shaping professional preferences. Historically, there have been traditional gender roles in many societies, which have influenced the professions that are considered "suitable" for men and women (Chapter Two, Section: 2.3.3.1, pages: 43-44). For example, nursing has traditionally been viewed as a female-dominated profession, while male-dominated professions such as engineering. These gender stereotypes can create barriers for individuals who may be interested in a profession that is not traditionally associated with their gender.

Gender inequalities can also affect the opportunities and experiences of individuals within the profession. For example, women in male-dominated departments like male urology could face gender-based discrimination. This gender inequality developed from the patriarchy culture (Chapter Two, Section 2.3.3.1,2.3.3.2, 2.8, page: 43-45, 64). In patriarchy, the role of the male as a leader is developed in individual mindset and psychology, and influences individuals' selection of the profession. On the other hand, the female's role has always been associated with serving family and caring. Therefore, it is important to understand culture to deal with these issues in an appropriate way such as staff distribution and scheduling.

4.5. Professionalisation of Healthcare

In order to develop TVNs, the outcome from the semi-structured in-depth interviews is generated in three main themes and sub-themes as given in Table 4.2. Understanding these themes would provide an understanding of healthcare professionalisation. The professionalisation of healthcare refers to the process by which healthcare becomes a formalised and regulated profession, with clear standards for education and qualification (Reed et al., 2019). Professionalisation aims to improve the quality of the care provided through highly trained, competent, and qualified nurses (Chapter Two, Section: 2.3.3, page: 42). This will further enhance the prestige and recognition of nurses, as well as boost the figure of the nursing profession. Therefore, the professionalisation of nurses requires competent individuals with special knowledge, skills, and expertise in providing healthcare services like TVNs in skin and wound care. This will involve developing formal educational programs and rigorous training, to ensure that nurses meet specific standards of knowledge and skills to provide safe, effective and high-quality care to patients, particularly in the area of skin integrity and wound management.

Table 4.2: Research Main Themes and Sub-themes

Theme No.	Main Theme	Sub-them 1	Sub-them 2	Sub-them 3	Sub-them 4
Theme 1	Power and authority	Policy and workforce planning	Planning and training	Leadership and Administration	Infrastructure and resources
Theme 2	Inability to exercise nurses' own knowledge	Awareness of the profession	Trust and decision making	-	-
Theme 3	Culture influence	Inter-departmental factors	Gender inequalities	-	-

The following respondents shared their views about the professionalisation of healthcare:

From Egypt:

> ***Ah. S#E:*** *To enrol in nursing you need to have 90% and we have master's degrees and PhD programmes, these degrees help us to have the knowledge and make better decisions.*

From Jordan:

> ***Ta. E.R#J:*** *Competent environment in Jordan, I think we have continuous training. In my batch, we have 300 nurses all of them have masters in nursing. Everybody wants to have the knowledge and use it effectively in discussion with others, or participate in conferences, especially for men who do not want to see other men have more knowledge than them.*

Also,

> ***Ta. O.T#J:*** *We have specialities such as wound care nurses, nursing diplomas and higher studies. People come from outside the country to study nursing here.*

Further,

Sa. I.C#J: *Specialised nurses usually compete with other nurses to have more knowledge for better working opportunities.*

Hu. S#J: *Those nurses will give special care for dressing and wounds, they will have more knowledge than other nurses in wound management, because they studied more, and all of them receive continuous training and have Master's degree.*

From Qatar:

Me. U.S#Q: *Specialist nurses in wound management could make better decisions because they have attended more training and they all have Master's degrees.*

Lu. O.G#Q: *We have a speciality for wounds and skin, they are specialist nurses with Master's degrees and they attended special courses in the UK and Canada to manage wounds and do detailed assessments for the skin.*

Most of the participants in Jordan referred the specialised nurses in wound and skin care to their level of study or degree where most of those specialised nurses actually have Master's degrees in their area of speciality. This could show the impression that specialised nurses as competent. Although not all the health sectors in Jordan have specialised nurses in wounds, still the nurses are more concerned about improving their skills and knowledge to shift to academics where there is a good opportunity for professional development and improvement. Further, it is appropriate in terms of salary and status.

4.5.1. Sharing Thoughts about Selecting the Nursing Profession

From Jordan:

Sa. I.C#J stated:

Actually, I do not want to go for the nursing profession, but my name was in nursing college. I applied for engineering, so I was shocked when they put my name for nursing. Initially, I was upset but my family encouraged me to be a nurse because they gave me too much support.

From Kuwait:

> ***Re. O.P#K**: Somehow my sister influenced me to be a nurse because there is a very good opportunity to work quickly.*

Further,

> ***Sa. O.P#K:** I became a nurse to support my family, my parents cannot afford all the expenses, and we are 3 sisters, so I said I will be a nurse to work in the Middle East and I support my family for my sister's marriage.*
>
> ***Al.. S#K:** Partly family influences me, it was because, you know, it is a profession where you can get a job easily. You will not be sitting at home without a job. I had a passion for taking care of people and since my childhood, I used to love it. And you know, I loved taking care of people. Yeah, one part of me always loves to travel the world. So, I like to travel the world. You know, I had to work. I love to work. And also in between I had to travel the world so that time, you know, it was a time when* understanding the culture *of the people you know, majority of the people used to go to, you know, nursing. And I came to know about nursing, and I knew that, you know, I could work in any country. So, there was like, you know, your passion to be a nurse and passion to care for patients. My mom used to say not from childhood, but when I was old enough, she told me that it is a better job, and I was carrying a bag all the time, most of the time, with plaster, bandages, and alcohol wipes, I used to clean their wounds in the family if there is.*

In Qatar, one of the nurses expressed that:

> ***Pe. S#Q:** Easy to get a job as a nurse in India, that is why I chose nursing, but our salary is much less there. That is why I and others are coming here in the Middle East.*

Also,

> ***Sa. U.S#Q:** I became a nurse because it is easy to find a job.*

Further, from Kuwait

Re. O.P#K: *I want to travel to Canada and explore the world; with this profession it is possible.*
Al. S#K: *I like to explore the world. I like to travel to another part of the continent.*

Participants shared that the decision to be a nurse relies on different factors. One of these factors is that the nursing profession gives the opportunity to work abroad, to travel and to have exposure to the world. The nursing profession also enables nurses to practise their academic skills and can have higher degrees such as a Doctorate or Master's degree which is part of professional development. Further, nursing can have different specialities such as surgical, medical, maternity and paediatrics and another speciality. Hence, developing TVNs will provide an alternative for nurses to choose among those specialities.

Another participant from Jordan stated:

Hu. S#J: *I am happy to be a nurse, even with a lower salary but at least I have a job. I am not homeless.*

Being a mother could impact the decision of a career, for example, one of the participants shared that the main reason for her to enrol in nursing school is because she has a child with a genetic disorder. She stated:

Hu. S#J: *After getting married and having my daughter with a genetic disorder I decided this is the time to do what I like and to study nursing.*

Family can also influence the choices that individuals make regarding their profession. This reflects that the selection of nurses could be for several reasons which reflect the positivity and advantages of the nursing profession.

4.5.2 Different Perspectives to Develop Tissue Viability Nurses (TVNs)

The development of TVNs in tissue viability from different stakeholder perspectives: policymakers, nurses' profession (General Nurses, Nurses-team Leaders, Head Nurses), Nurses' Leaders (Nursing assistant director, Nursing director), doctors, and Hospital Directors. The details are given in Table 4.3.

Table 4.3: Perspectives to Develop TVNs

Policy Maker Perspective From (Kuwait):	Nursing director perspective From (Kuwait):
Hu. P.M#K: *It is important to have a new nurse's speciality, but we need to follow the organisation's vision and mission, mmmmmm,,,, the strategy we cannot change because it is long-term, but to have a new nurse's speciality we need a strategy and policies but where is the strategy …. We cannot find the strategy or policy maybe they are available or not.* *We have no idea.*	***Fa. N.D#K:*** *Yes, it is more productive to keep specialised nurses for wound and skin integrity in each department. Those nurses will have more knowledge about cleaning wounds and changing the dressing appropriately. This will improve patient care, and we are working at the end for the patient's benefit.*
Ha. A.D#K: *I think it is important to have a nursing speciality in the area of skin and wound management. As a manager our responsibility is to follow the training programme of those nurses and follow up, then send a report to the ministry of health explaining the need for more training or other resources.*	***Ma. N.D#K:*** *We have nurse instructors, and they are more aware of patients' and services' needs. For that, I cannot give my opinion regarding developing a new speciality, because we do not have this speciality. I cannot guarantee it will be beneficial or not. but if we want to develop this area of speciality we must plan for this appropriately and discuss with the nursing directorate to provide training for nurses in this regard.*
	Ka. N.D#K: *Yes, they are important, but those nurses cannot be beneficial during the pandemic because of the nurse shortage, we have to focus on important aspects of care for now.*

Nursing perspective: Kuwait	**Nursing perspective:** Jordan, Qatar and Egypt
Sa. O.P#K: *Very important to have a specialised nurse for wounds because they are focusing on a particular area, so they can give better care then meet patients' needs. Also, they can teach other nurses.* ***Th. U.S#K:*** *I have been working here since 2015, and we are using the most advanced equipment and machines and everything on the computer. Here they focus on the quality of care, and I think if we have specialised nurses, we can improve the quality of services because they will follow the policy and rules to improve wound management.*	**Jordan:** ***Ta. E.R#J:*** *I saw those nurses in Australia while I was working. Also, in Jordan, we have a nursing speciality in the skin and wound management. Actually, in Jordan, we have a nursing speciality in the skin and wounds but in the private sector only.* ***Ta. O.T#J:*** *Yes, could bring a positive environment, when the doctor's workload reduces due to our knowledge in skin and wound management then the doctors will focus on other critical cases, and we will deal with the wounds.* ***Sa. I.C#J***.: *The nursing speciality in wound and skin care will improve the services, and the nurses will be knowledgeable about the area of interest.*
Al. O.P#K: *Definitely going to be positive, it is going to be healthy, and the patient will recover soon, and it will have a positive impact on nurses' careers, mmmm, especially in their medical career they will be recognised for their speciality.*	**Qatar:** ***Ba. O.T#Q:*** *Yes, I think they will be beneficial to patients, they will care for wounds properly, Maybe they will reduce work pressure for nurses, no idea exactly I am not sure about that.*
Re. O.P#K: *The main thing for having a specialised nurse is to improve hospital care for patients. So, basically, I think those*	**Egypt:** ***Th. O.P#E***: *I think specialised nurses will reduce the workload for other nurses. Any*

nurses will reduce the workload for other nurses by managing wounds and following them till improve. But the other thing is patient satisfaction so if the patients are happy with general nurses and those nurses doing their job, I think there will be no need for specialised nurses. In the end, all are nurses and there is not much difference.	*nursing speciality if we have, will help to improve the care, because specialised people have more knowledge than general nurses.* ***Ab. U.S#E:*** *I do not think the specialising nurse is a good idea here, It can be negative also if there is a nursing shortage and those specialised nurses are not familiar with other aspects of patient care, hence, we cannot benefit from them in case of emergency.*
Ti. O.P#K: *Here we do not need specialised nurses, we are doing all the work together. MMMM,,, I think they are good for patients but not for general nurses. We are doing everything for patients and if the nurses will be specialise in wound care, they will be in the dressing room only. And we cannot assign them to other clinics because they are not familiar with the routine.*	
Ri. U.S#K: *In my view, specialised nurses can improve the daily care for patients as well as the organisational set-up, it will be good to have a special department for wound management, this can improve the quality of services and patient care. It could be negative also because those nurses are focused on their area of speciality only. For example, if there is a procedure like catheterisation those nurses could not be familiar with the procedure. So times patients have special needs or during an emergency, those nurses cannot deal effectively with different situations.*	

4.6. Challenges for Nursing Profession

In expressing the positives of TVNs developing nurses' speciality would robustly improve the quality of care and further will also reduce the work pressure for doctors. However, there is a concern about nurse's duties, whether they can help in a general routine task, or their role is limited to skin and wound care. Some issues need to be managed first, such as staff shortage and workload which are significantly affecting the development of TVNs. Organisational challenges that are associated with the first theme (power and authority) are illustrated in Figure 4.7.

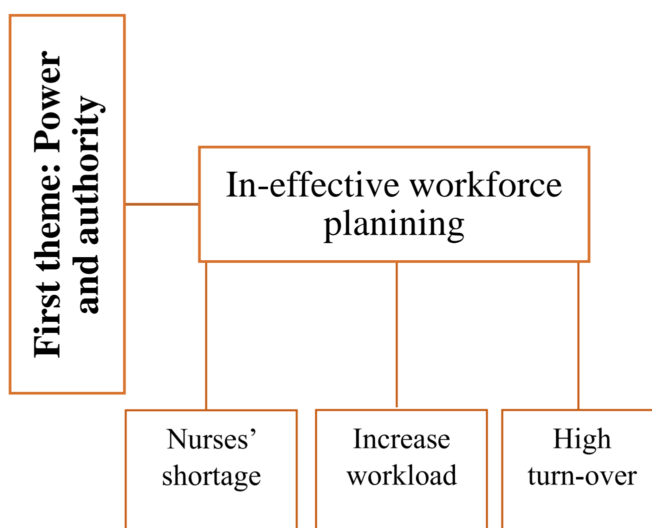


Figure 4.7: Organisational Factors

4.6.1. Ineffective Workforce Planning

Ineffective workforce planning can have various consequences on the organisation as well as the staff and patients, for example, high turnover and low productivity. For example, understaffing can have several negative consequences, if the organisation does not accurately estimate its workforce needs, it might end up with an insufficient number of nurses in each department. This, in turn, could result in reduced productivity and efficiency of the nurses and then they will be more likely to make mistakes which can ultimately impact the quality of the healthcare service. For example, with a smaller number of nurses, it might be more challenging

to provide wound specialist training as mentioned in section: 4.2.1 (page: 148). Nurses could do dressing for patients but with less concern about the quality, due to workload stress, nurses might forget skin and wound assessment as it might be difficult to manage the time with each patient. Therefore, providing TVNs will help to focus on this area of wound and skin care and general nurses will focus on other aspects of care. The following respondents share their thoughts about that.

From Kuwait:

> ***Hu. P.M#K:*** *As I know we have a nurse's shortage, so how to build a new nursing speciality, the indicators said something, but the reality is different. The staff ratio is very old and even old we cannot achieve, no plan to sustain nurses or other medical teams. We do not have a plan for emergencies and even if hospitals have, they do not implement it.*

> ***Ma. N.D#K:*** *No proper policies or planning. We do not have a common goal with the Ministry of Health.*

> ***Fa. N.D#K:*** *I really support starting a nursing speciality programme in Kuwait again. If we have a nursing speciality, we will give more to the patients which could improve their condition. But if you are a general nurse you will struggle, sorry to say that,,, but every day they will transfer you to another department. I have experience in the Intensive Care Unit but, they were still transferring me to a different department from the nursing directorate regardless of my area of experience or my knowledge, then I wrote a letter to the undersecretary for the allied health department in the Ministry of Health and requesting him to avoid transferring me to a different department that is not relevant to my experience.*
> *We do not have proper planning and policy but if we have a policy that supports specialised nurses, no one can transfer me from one department to another. Mmm, I support nurses to be familiar with everything related to patient care, this will be beneficial during the crisis and will reduce the workload for other departments. But only during a crisis, we can transfer nurses to another department. Apart from that,*

specialised nurses must work in the area of their experience and knowledge. It is not nice every day to transfer you here and there.

From Qatar:

Sa. S#Q: *Good to have different specialities but staff should be enough, I think it is good for patients, but for nurses more work. uh, like for FIFA, we already have a shortage, and they took from our staff. Matrons asked us to arrange the staff, and they know we have a shortage.*

Pe. S#Q: *No job security here. If tomorrow told us to go, we have to go. No other choice.*

El. S#Q: *The cost of living is very high over here, so most of them try to have a better life. We have to think about our family, they are bringing up the family, the children, and education all available in the UK. The children's higher education and all it is good. The thing is that for general nurses the salary is comparatively less than for registered nurses. But also, Uh. The benefit is that the night shift is not there, and we will get the public holidays on the same day and we are getting weekends correctly two days. That is most important. We can spend time with our family.*

From Kuwait:

Al. O.P#K: *The visa is not supporting us to bring our families. I came to the UK because of my family. They are supporting us from the point of doing an English test till we join the hospital. In the Middle East when I came to Kuwait, I only came to know my contract was with the company not with the Ministry of Health, less salary, I could not bring my family on visit visa, I hated it. I really did (eyes got wet). I want my children to be with me, I want them to receive free medical facilities and education for free like other citizens. If I am not happy, I cannot make patients happy, it was challenging.*

4.6.1.1 Staff Shortage, Increased Workload, and High Turnover

Ineffective workforce planning can also lead to a high turnover rate, if the organisation is unable to provide nurses with adequate career development opportunities and training, nurses might look for better opportunities in other countries, resulting in high turnover. One of the participants who left her children and family to work in Kuwait anticipated difficult emotions. Other respondents raised difficult emotions for nurses to work effectively while being separated from their families and children. Therefore, the researcher must focus on the clues and words any repetition or emphasis for the words could help to develop themes and codes. For instance, **Al. O.P#K,** is an Indian nurse working in Kuwait stated:

> *I cannot get my right to bring my family there. Here in the UK health facilities is free for all. You know, civilians here, those who live here. So, it does not matter whether they are poor or rich. So, you know the healthcare facilities are open for all of us, all of the people. You can help people and do dressing. In the Middle East, I cannot bring my children to the hospital or my husband. They have to pay fees not for free. In the UK they look after their civilians, I am very glad to use the opportunity to work as a nurse in a country like the UK and I am really enjoying it.*

Also, another issue that arises is related to job security, where the nurses feel insecure in their current job, therefore, they resign and look for other options. Other foreign nurses who are working in Qatar, expressed the difficulties of staying away from their children. Although the visa supports nurses to bring their families, however, the policy allows the children to stay in the country till age 18 and after that, they have to leave the country. Consequently, this drives those foreign nurses to leave the country.

From Qatar:

> ***Pe. S#Q:*** *All of us are doing our job, but now we have a shortage and workload increase. even when we worked during COVID-19, we did not receive the allowance. Maybe we should think of reducing staff shortage and then better focusing on other areas. Nowadays all of us are thinking of leaving.*

Ni. I.C#Q: *We do not need special nurses, because we have a small department, we can manage our work alone but if there will be special nurses, we have to train them and we do not have time, this will increase our workload. Maybe other departments need them like surgical, it will be better.*

El. S#Q: *I prefer not to have specialised nurses now, it should be later, when we have enough staff, now so many resignations and difficult to manage work. In a normal situation, we lack staff, and we need more general nurses to cover the work and other tasks like going to the pharmacy and routine nurses' tasks.*

From Kuwait:

Ma. N.D#K: *A common issue for nursing worldwide is nurses' shortage, especially after COVID-19.*

Fa. N.D#K: *If we have a specialised nurse for wounds and skin the workload will decrease for other nurses, also I can use their skills as nurses to cover the shortage of general nurses in the departments. I have the right as a leader to delegate different work for them apart from the area of their speciality like helping in different assignments for pharmacy, biomedical or general store. Then the workload will decrease for other nurses. This is if we do not have patients with skin issues or wounds, and of course, I will use them according to work needs. Did you understand what I mean,,,, Those nurses with a different speciality by profession are nurses, so I expect them to know how to care for the mother and newborn, be familiar with all types of medications and medications administration, they can fix cannula and do bed making, This is basic knowledge as a nurse cannot refuse to work in any department, they must follow the rules and support in any crisis. When we have no crisis or nursing shortage then those specialised nurses can work in their area of specialities. At least if I need nurses to prepare newborn milk formula I can send them for this type of job, we do not have much time to teach her these.*

Al. S#K: *Shortage of nurses, understaffed the majority of the time and it is more or less, which makes mistrust.*

Ri. O.P#K: *Staff shortage, especially during the pandemic. This nursing speciality will increase the workload. And those nurses will not be able to help us if we need help. I think general nurses do more effort than specialised nurses. We can do anything for patients, but special nurses will do dressing only then we will not benefit from them during an emergency and cannot be useful for us.*
Ri. O.P#K: *I am from India, and I worked in the ICU for two years. I moved to Kuwait in the outpatient department, and now I am applying to Canada for migration.*

Wa. D#K*: We need manpower, we do not want nurse's turnover. If we train specialised nurses, then they will leave abroad for several reasons. I think high turnover is affecting efficiency. Because after training the nurses tend to leave.*

There is a fear associated with developing TVNs for several reasons such as increasing the workload for general nurses during the emergency. The participant's responses show that there is ambiguity and misconception in the responses about the specialised nurse's role. Participants shared their thoughts about their duties and responsibilities, where there is more emphasis on staff shortage and difficulty in managing menial tasks, such as going to the pharmacy, bio-medical, collecting prescriptions or getting stationery from the general store in the hospital along with attending training and providing care for patients.

4.6.2. Challenges Associated with Third Theme

Organisational and cultural challenges that emerged with the third theme (cultural influence) are depicted in Figure 4.8.

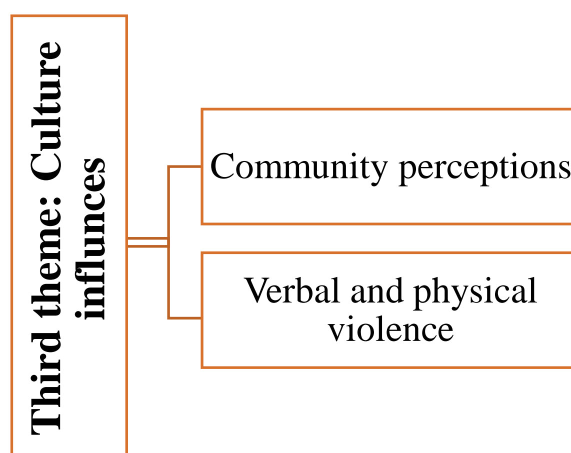


Figure 4.8: Organisational and Cultural Challenges Associated with Third Themes

4.6.2.1 Verbal and Physical Violence

Verbal and physical violence are two forms of aggression that can have negative consequences on individuals and society (Dafny and Beccaria, 2020). Verbal violence refers to the use of language to harm, intimidate, control, or humiliate another person (Koller and Darida, 2020). It can take many forms, including insults, threats, and belittling. Verbal violence can have serious emotional and psychological consequences and can leave lasting scars on the victim such as low self-esteem, anxiety, and depression. On the other hand, physical violence involves the use of physical force to harm another person (De Puy et al., 2015). This can include hitting, punching, kicking, choking, or any other form of physical attack. Physical violence can result in serious injury or even death and is a criminal offence in most jurisdictions. Both verbal and physical violence can be used as a means of control and domination and are often used in situations of power imbalance, such as in abusive relationships or in the workplace. Violence is a serious form of aggression that can have a range of negative consequences for those involved. Therefore, the health organisation must develop a plan to prevent and address instances of violence through regulations and legal action when necessary.

From Kuwait:

> ***Fa. N.D#K:*** *We have a nursing association which is not supporting us, for anything. Community perception and patient and relative violence (physical or verbal). This makes no value for nurses, there is no motive even to develop a new speciality.*
>
> ***Al. S#K:*** *Most of the time I used to get treated by the patients and the doctors badly in general medicine.*
>
> ***Sa. O.P#K:*** *I had a problem initially because I was a junior, so I did not understand the policy and not following it the way it should be. Some conflict was there with seniors because seniors always want respect, and they are the ones teaching the juniors the policies. So, I did not understand the system here, and then supervisors were angry with me, and they sent me to another department.*
>
> ***Int.:*** *Why?*

Sa. O.P#K: *The supervisors have non-cordial behaviour, when supervisors are coming and you know cultural differences, I was not familiar with the rules like I was not following the culture, or you can say the policy. Then I understand the policy and system.*

Ti. O.P#K: *Patients do not respect us, every day there is a problem, they use verbal violence and just shout, if we tell them to wait in the waiting area, they will get angry. The clerk actually, pushing them to go into clinic corridors and lose their files, but the patients fighting with us only.*

Ri. O.P#K: *Harassment, partiality, some attitudes like taking revenge if our incharge is not there all supervisors will come to us and shout for anything.*

From Qatar:

Me. U.S#Q: *Sometimes, I find it difficult to keep reading all the time, but I challenge myself I see how in Qatar nurses have voices and no one can insult us. Here we are working like a team, all respecting nurses, not like in other countries where anyone can insult us or be rude.*

Further, from Jordan

Mo. I.C#J: *The administration is always supporting us. If there is a conflict with the doctor or violence from patients or relatives. Like verbal violations.*

4.6.2.2 Community Perceptions

From Jordan:

Ta. O.T#J*: In Jordan, male nurses are more than female nurses because of community perception, for example: females avoid taking nursing jobs because it is difficult for them to marry due to their work nature and different shifts and further working in male wards. Because of community perception, some families are not accepting their daughters to study nursing because of night shifts.*

Further, **Ta. E.R.#J** had a grin when asked about the community perception and its influences on the nursing profession.

> ***Ta. E.R#J:*** *For sure, especially if I am a male nurse, some families reject male nurses from marrying their daughters and some think the nursing profession is for females only. The community looks for nurses as lower than them which is why I am working now with the IT department. Many people are changing their careers or continuing their higher education to be in the teaching field.*

There is more concern about public perceptions in Jordan, to encourage the female to enrol in the profession, they were giving some rewards, just to encourage the female to enrol in nursing. On the other hand, in Egypt, the community is looking at the nursing profession as important as doctors. Nurses are allowed to start their clinical practice in villages and other cities, where they can practise their skills in maternity care, wound management, and fracture.

4.7. Other Challenges for Nursing Profession

Language and communication difficulties are considered challenges for foreign nurses who are majority in Kuwait and Qatar.

> ***Fa. N.D#K****: The nursing profession is full of challenges, salary is less compared to other professions such as teachers, a high risk of infection or injury, so many nurses get Deep Vein Thrombosis (DVT), back injury while lifting heavy patients. In addition, visitors' violence and have no respect.*

> ***Sa. O.P#K:*** *I did not have much idea about what is the Ministry of Health and what is under the Ministry of Health. I heard that when we have to go to Kuwait, we have to pay around 18 to 20,00,000 R.S, which is around 5,000 K.D to the agency so I paid. We have no option but to come to the Gulf.*

From Kuwait:

Hu. P.M#K: *We might struggle to develop new nursing especially now because of workload and prolonged stay in the hospital. In general, nurses' shortage issues is in Kuwait but we have to deal with this.*
Like for me the pandemic and COVID are not an obstacle but the people who do not want to work make COVID an excuse. But the workload has increased because of the pandemic.

Re. O.P#K: *Mainly the language barrier and salary are not enough if you want to bring your family.*

Al. O.P#K: *Communication was a big barrier for me. But I and other nurses tried to learn Arabic words by asking others to teach us. Like the receptionist or other Arabic nurses and it is difficult to talk to senior staff.*

Ri. U.S#K*: We face communication problems here.*

Sa. O.P#K: *Actually, when I went to selection to Kuwait, I was very excited because most of my friends were there in some other Gulf countries. So, I was waiting to get anywhere to upgrade my profession and I was really excited. But when I entered Kuwait, language was the primary barrier for me because I did not know even a single word of the Arabic language.*

Some rules and regulations demotivate nurses which has a negative impact on the nursing profession like staff shortage, increased workload, staff depression, low salary, a high risk of infection, Deep Vein Thrombosis and back injuries. Further, verbal, and physical violence, visas, immigration policies and salaries. All these aspects are barriers to professional development. This led to high resignations in Kuwait, Qatar, Jordan and Egypt and most of the nurses are leaving for Western countries. Besides, the majority of the respondents stated that nurses are taking lower salaries, although they are doing a difficult job. Regarding the salaries, there are two aspects. The Jordanian and Egyptian participants highlighted that there is a massive difference between their salaries and the salaries of people working in Kuwait and Qatar. Apart from salary, improving the professional status of nurses is required to solve the previous issues. It would be difficult to develop a nurse's speciality related to wound and skin

care. How the profession will improve if there is no respect or there is verbal and physical violence, there will be no desire to improve the profession. Therefore, to improve the professional status of nurses, first, enhance the awareness of nurses' role by getting media support to show the world the role of the nurses during COVID-19, the policy should support the nurses and protect their rights as an employee. Additionally, the findings from in-depth interviews reveal the main challenges for the professionalisation of nurses as illustrated in Figure: 4.9.

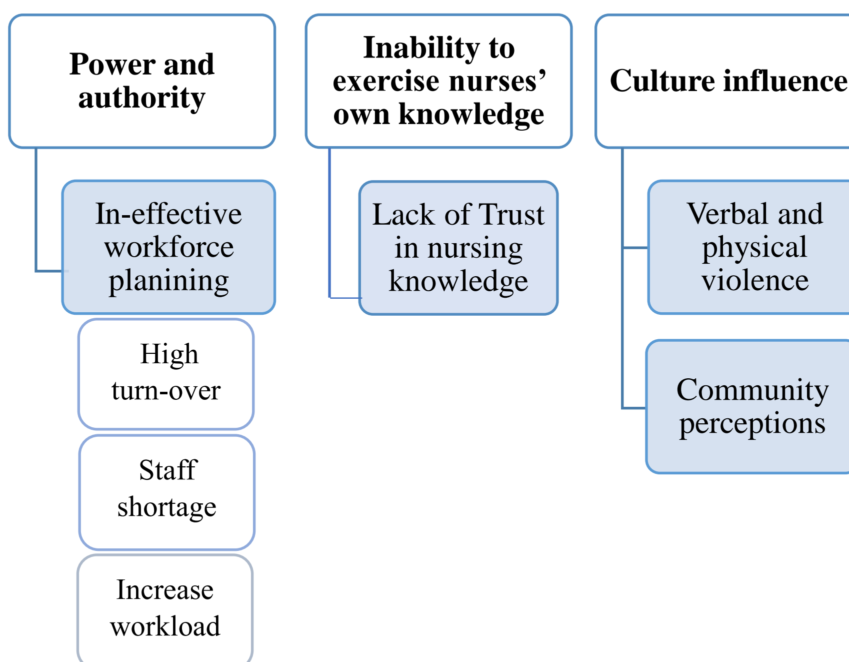


Figure 4.9: Main Challenges for the Professionalisation of Nurses

4.8. Summary

Doctors have been always recognised as experts in their field and they are more likely to be valued by patients and policymakers. A doctor or physician is a prestigious profession that gets people's respect, whereas the nursing profession is not. Therefore, there is an issue related to the power and authority that stops nurses from leading. In which the nurses' directors clearly stated the policy is developed by the Ministry of Health, but it does not have any connection to what is happening in practice, except to be a sort of barrier. There are different attitudes toward the policy, and it influences decision-making. This could refer to control of the power and authority that is given to nurses that might be associated with resistance and other challenges. Senior and junior nurses have different thoughts, usually, senior nurses who are in administrative or managerial positions have different priorities and agendas that interfere

with general nurses' priorities. Therefore, the ideas or thoughts vary from one individual to another, which is also influenced by several factors such as the hierarchical level or job description and cultural background, policy, workforce planning, training, and career development opportunities.

CHAPTER FIVE
DISCUSSION OF FINDINGS

5.0. Introduction

The research findings and discussion are critical components of any research. This chapter highlights the literature review outcome and provides a detailed discussion with the interpretation of the research findings in chapter four, by using a thematic analysis. Therefore, the literature review and interview findings provide essential information to understand the contextual factors, opportunities, and challenges that influence the development of TVNs in Kuwait, Qatar, Jordan, and Egypt. The outcome of applying a generic qualitative approach helps to understand the development of the nursing profession and the absence of TVNs in the respective countries.

5.1. Summary of the Research Findings

This exploratory research aimed to acquire new knowledge related to the current nurses' role related to wound management and skin integrity and understand the reality of the decision-makers and gatekeepers regarding the absence of TVNs in Kuwait, Qatar, Jordan, and Egypt. Furthermore, through the lens of professionalisation, it explores nurse's ability to develop TVNs in their respective countries (Chapters Two and Four). This research moves beyond exploring nurses' roles related to wound management and skin integrity, it is also conducted to understand the facilitators and barriers to developing the TVNs and use these facilitators to strengthen nursing positions in the healthcare system, as a knowledge producer. From a sociological perspective, the generic qualitative approach facilitates understanding the nature of individual behaviour and role in organisations, including understanding human thoughts and internal aspects such as fear and threat, which are barriers to developing TVNs in the respective countries (Chapter Three, Section: 3.4.2., page: 100). Hence, the findings from conducting in-depth semi-structured interviews are presented in three main themes, for more precision and clarity in the data these themes have been classified and divided into sub-themes. The themes addressed the research questions and objectives as illustrated in Figure 5.1.

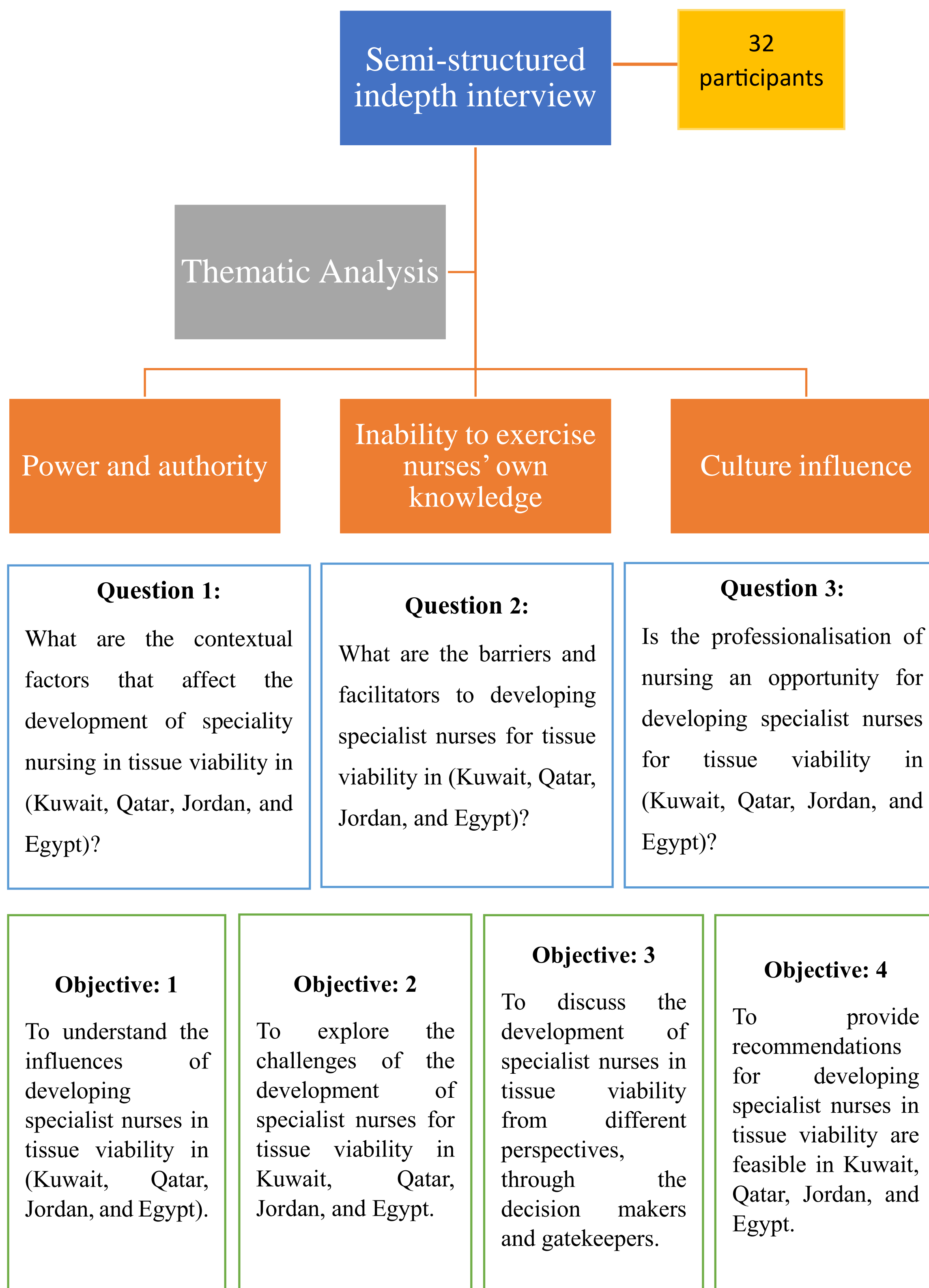


Figure 5.1: Previous Chapter Findings with Research Objectives and Questions

The professionalisation of nurses empowers nurses in decision-making (Chapter Two, Section: 2.2, page: 36), and decision-making is a key element for the TVNs (Chapter Two, Section: 2.3.6, page: 57; Section: 2.6, page: 60). It involves nurses' knowledge related to chronic and complex wounds, in order to avoid complications such as social isolation, depression, or amputation (Chapter One, Section: 1.3, page: 8). However, to achieve this decision-making stage (the stage at which nurses make and take decisions), this research revealed several issues and barriers that impede nursing decision-making. These barriers are associated with social, cultural and organisational factors such as issues of power and authority, organisational culture, domination and discrimination issues, gender inequalities and lack of policy, which in turn hinder individual ability to make decisions. The findings also revealed that in reality empowering nurses in decision-making is a complex process that requires more than simply nurses holding knowledge (Chapter Four, Section: 4.3, pages: 161-166; Section: 4.4, pages: 170-173). In the context of developing knowledge related to wound management and skin integrity, nurses need the infrastructure and different resources, including times for meetings and conference rooms for adequate training and administration support. However, nursing cannot progress and make decisions if the organisation's administration does not show interest in nursing training and professional development. The finding of this research illustrates that the decision-makers gave less consideration to developing the nursing profession in Kuwait, Qatar, Jordan and Egypt due to the cultural influences and social status of the profession. In order to understand the reality, a qualitative approach was applied to provide a detailed understanding of the organisational, social and cultural context in which individuals behave and practice in the system. This also leads to understanding the absence of TVNs in Kuwait, Qatar, Jordan and Egypt.

5.2. Discussion and Interpretation of the Research Findings

The literature review and the findings of the interviews manifest that developing specialised wound nurses in Kuwait, Qatar, Jordan and Egypt; requires analysing several issues at different levels, as follows:

5.2.1. Individual Level

At an individual level, this research explores the absence of the nurse's specialisation and the role of nurses related to skin integrity and wound management in Kuwait, Qatar, Jordan and Egypt. The issues that have been explored in the findings are beyond nurses' control such as issues of power which are associated with fear and silence. The finding was executed in two stages: while approaching the participants and during the interaction with the participants. The preliminary emerging result manifests that participants are divided into two groups, one part of the participant shows that individuals are reluctant to participate in the research. The second emerging part is silence which avoids giving authentic answers, so individuals try to give an ideal answer that does not apply to real situations and contradicts reality. The issue of silence has been discussed in Chapter Two (Section: 2.3.5.1.1, page: 54). In social science, silence is described extensively through different theories and frameworks such as feminist theory, cultural anthropology and social constructivism framework. Therefore, the social constructivism framework focuses on the role of language and social interaction in shaping the researcher's understanding of the world (Van Dijk, 1997; Jung, 2019) (Chapter Three, Section: 3.3.1, page: 92). In social interactions, silence can be used to maintain the organisation's norms and avoid resisting them. Therefore, the social constructivist framework highlights the importance of understanding what is behind this silence and then contracting the social reality based on the understanding. From a social perspective, the silence concept can be approached from various theoretical dimensions to acquire a deeper understanding of the role of nurses and other healthcare providers related to wound management and skin integrity in Kuwait, Qatar, Jordan and Egypt. Some respondents from Kuwait, Qatar and Egypt were not expressive and stayed silent (using head movements and smiling) instead of sharing their thoughts, which reflects some issues of fear and avoidance. The link between avoidance/fear of expression and defensive behaviour has been previously identified in the literature review (Chapter Two, Section: 2.3.5.1.1 and 2.3.5.1.2, pages: 54-55). Despite that, the participants from Jordan were expressive and clearly shared their thoughts. It was also apparent that the participants were hiding behind the official policy position.

In this research, semi-structured in-depth interviews were used to capture individuals' actions and behaviours, in order to understand how they could influence the development of TVNs in Kuwait, Qatar, Jordan and Egypt. For example, when participants such as nurses feel uncomfortable talking about the issues in the organisation then it is difficult for the researcher to understand the issues within the organisation (Chapter Three, Section: 3.6.3, pages: 111 -

113). At the individual level, there is also a lack of knowledge and awareness in the research process, for example, a lack of trust that the information would be dealt with confidentially, such as scrutiny issues from Western examiners (Chapter Three, Section: 3.5.2.2, page: 107; Chapter Four, Section: 4.2.1, pages: 147-153). Therefore, the finding illustrates that individuals prefer to keep silent rather than share organisation issues due to the organisational behaviour and culture which was clear during the data collection process and findings. Individual silence affects organisations negatively and eliminates the chances for improvements as already explored in the literature review (Section: 2.3.5.1.1, page:54). This research intended to hear nurses' voices and explore the silent voices of the nurses and what is behind this silence of fear and lack of trust in individuals. Besides, the research discovered unhidden aspects related to the role of nurses in general and how their role impacts decision-making and wound management. The finding shows there are misunderstandings of the role of TVNs, which leads to fear of changing nurses' current roles. For instance, the findings from Kuwait, Qatar, Egypt and Jordan show that nurses have no clear ideas about the particular role of the TVNs, the explanation of this aspect is given in Figure 5.2.

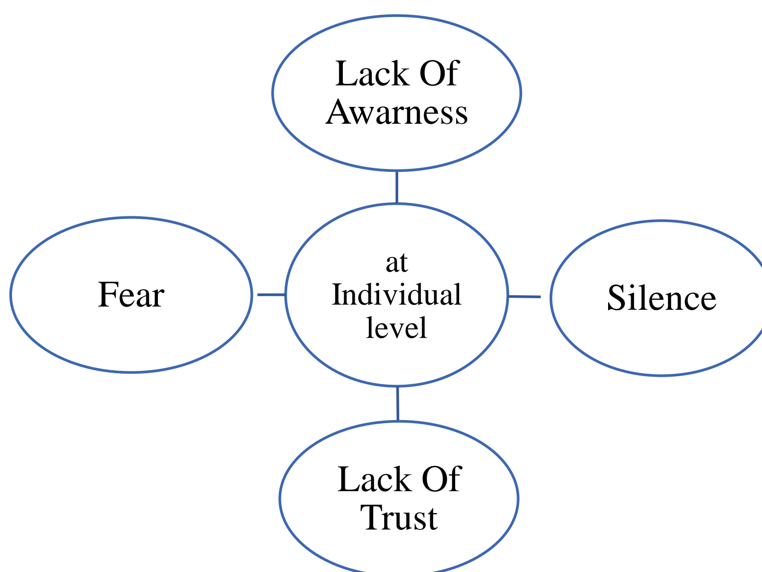


Figure 5.2: Emerging Issues at the Individual Level

5.2.2. Organisational and Structural Level

From a sociological lens, the development of the TVNs in Kuwait, Qatar, Jordan and Egypt is influenced by various structural and organisational issues that affect the social aspects of healthcare. This refers to individuals' interactions and communication with patients and other healthcare providers, it also encompasses their relationship with the administration. For example, nurses' engagement and contribution to health services are developed based on their understanding of community concerns regarding their wounds and skin problems. It is necessary to enhance nursing professional development and expand the opportunities for nurses to continue their education as part of nursing professionalisation (Chapter Two, Section: 2.2, pages: 36; Section: 2.5, pages: 59). This can improve nurses' general knowledge and skills and boost nurses' ability to deal with chronic and complicated wounds. Hence, developing nurses' roles related to tissue viability requires organisational or governmental support and funding to invest in nurses' education, provide training and access to the library to boost nurses' knowledge and skills. However, the findings from Kuwait, Jordan and Egypt revealed that cyberspace and library access is restricted to doctors only, reflecting an unequal distribution or allocation of resources (Chapter Four, Section: 4.2.4, pages: 159-161). In Kuwait, the findings also illustrate there is limited access to accredited wound care nursing programs, which makes it difficult for nurses to develop as TVNs. In contrast, nurses receive intensive training in Qatar. However, even with the existence of effective policies such as training and development, some factors undermine the potential benefits of these policies. In the case of Qatar, the training and development of policy do exist, despite that, the staff shortage curtails the benefits of the training and development (Chapter Four, Section: 4.2.2, pages: 153-156). In Jordan and Egypt, the findings revealed that since the pandemic, training has been suspended. This research illustrated there is a lack of nurses' engagement in clinical research, a lack of organisational and administrative support, and a lack of a career structure that did not support nursing professional development in Kuwait, Qatar, Jordan and Egypt. These aspects are illustrated in Figure 5.3.

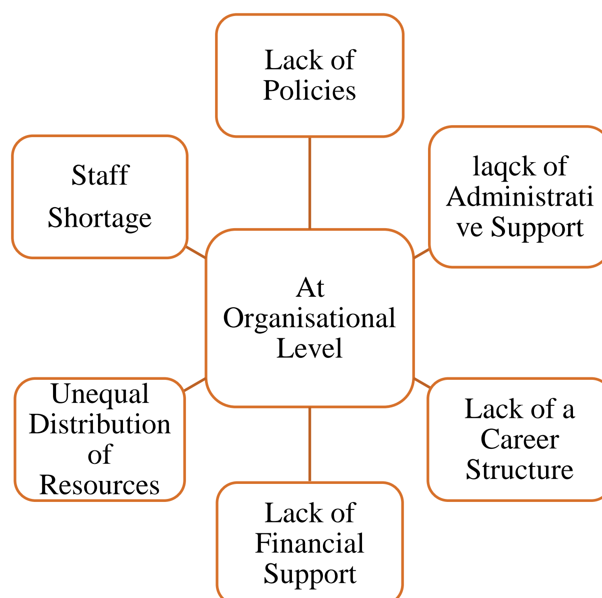


Figure 5.3: Emerging Issues at the Organisational Level

The findings also illustrated there is ineffective workforce planning (Chapter Four, Section: 4.6.1, pages: 186), and the organisation's management does not support nurses' professional development processes in the respective countries, due to the issues of power and control, lack of trust, domination, culture, discrimination and gender inequalities. These issues are taken into consideration in this chapter. Government policies and regulations can also influence the development of TVNs by providing insufficient resources or limiting the scope of nursing practice (Chapter Two, Section: 2.3.4, pages: 47-50; Chapter Four, Section: 4.3, pages: 161-167). Developing the policies and guidelines for TVNs can ensure that nurses are providing consistent care with advanced nurse practices. Although different views about the policy or lack of it were revealed from the findings. It was obvious from the research findings there was confusion between the policy and procedures, in which the participants were referring to the procedure as the policies (**see Appendix 5.1**). Participants respond differently regarding the policies, for instance, there is a belief that the policy and guidelines are already in place, although clearly from the data, it is not the case. This implies that the policy has been developed by the Ministry of Health, but it did not have any connection to what is happening in daily practice, further, individuals are not complying with it (Chapter Four, Section: 4.2.1, pages: 147-153). This supports the argument of Argyris and Schon (1992), Argyris (1995), Alias (2019) and Khatib and Barki (2022) that individuals' attitudes and behaviour vary toward

policies, not necessarily that all individuals following it in practice (Chapter Two, Section: 2.3.4, pages: 47). In order to effectively implement policies, management is required to provide sufficient training and follow-up to ensure that people are complying with the policy. For instance, policies can bring some changes in the system or increase individual responsibilities which can lead to fear and then resistance as explained in Chapter Two (Section: 2.2.1.2, pages: 39-40). The issues of resistance are associated with the organisational culture and behaviour as discussed by Nelsey and Brownie (2012) (Chapter Two, Section: 2.2.1.2, page: 39, Section: 2.3.5.1.1, page: 54; Section: 2.3.5.1.2, page: 55). The findings from this research illustrate the distribution of power in organisation (Chapter Four, Section: 4.2, page: 146), there was also a hidden aspect related to the policies in which it used to control nurses rather than improving care (Chapter Four, Section: 4.2.3, pages: 156-159).

5.2.3. Other Issues

The professionalisation of nurses helps to understand the development of nursing as a career (Chapter Two, Section: 2.2, page: 36). This development of the profession incorporates social and cultural factors, including cultural norms, tradition and beliefs, which can also pose a challenge to the development of TVNs. For example, cultural influences perceive the knowledge of nurses, who are lower in the hierarchical level in the organisation as mentioned in the literature review (Chapter Two, Section: 2.3.5.1, pages: 53-54). Further, developing a nursing speciality to some extent depends on patients and the community's willingness to receive knowledge from nurses. The finding illustrates that patients are not willing to follow nurses' instructions (Chapter Four, Section: 4.3.2, page: 168; Section: 4.4, page: 170-173). Therefore, these issues impact the ability of nurses to provide culturally sensitive care to patients. For example, in Arab and Muslim countries, male nurses are not allowed to work in female departments. Similarly, male patients do not accept female nurses to do wound dressing for them or provide care for them, due to religious and cultural restrictions (Chapter Two, Section: 2.11.1, pages: 78; Section: 2.11.4, pages: 81-83; Chapter Four, Section: 4.4, pages: 170-173). Therefore, it is important to understand the contextual factors, opportunities and challenges associated with developing TVNs such as considering culture-sensitive issues of providing care, along with society's norms and beliefs while planning. For example, developing specialised nurses in wounds requires providing an adequate number of male and female nurses to allocate to the departments according to the needs. Additionally, the contextual factors that impact the development of TVNs such as the shortage of human

resources and increase in the workload impede the nurse's progress and development as a speciality. Figure 5.4 shows the opportunities and challenges for developing TVNs.

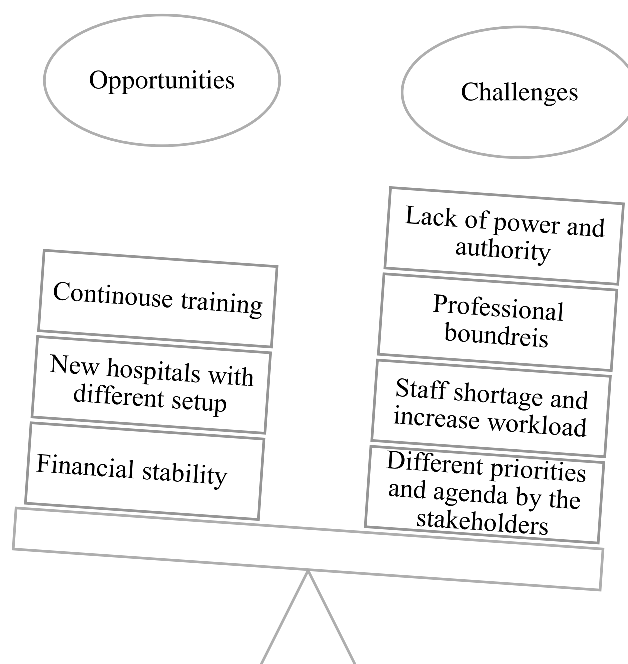


Figure 5.4: Opportunities and Challenges for Developing TVNs

5.3. Professionalisation and Flourishing Nursing Profession

The term flourishing regarding the profession refers to the state of thriving, growing, and achieving a sense of fulfilment and satisfaction in one's work. It involves more than just being successful in a career; it is about feeling engaged, challenged, and fulfilled by the work that one does (Pawelski, 2021). According to Tarafdar et al. (2020), setting clear boundaries could make a positive impact on the profession. For example, following national and international nursing guidelines, the nursing code of ethics, and professional training can promote the nursing profession (Chapter Two, Section: 2.8, page: 65). However, following these professional boundaries could be a source of stress and challenges for nurses. For example, in Jordan, the respondents expressed that the working environment is competent, and most of the nurses pursue higher degrees and constantly update their knowledge by attending conferences and specific training programmes to improve their social standing and get better working opportunities (Chapter Four, Section: 4.5, pages: 177-182). This prolonged training or ‘continuous professional development’ makes the staff tired and exhausted. Similarly, in Qatar, nurses expressed that they are exhausted due to continuous training programs (Chapter Four, Section: 4.2.2, page: 153; Section: 4.6.1.1, pages: 188). This supports Al-Ma'aitah and Momani (1999) arguments about organisational and employment factors that influence

achieving a high level of professional development for nurses. This level of development is associated with staff exhaustion (Chapter Two, Section: 2.5, pages: 59).

Seemingly, the professionalisation of nurses contributes to better nurses' practice by developing standardised knowledge and skills related to wound management by focusing on the area of assessing and managing wounds, preventing complications, fostering the healing process and developing new knowledge related to wound management and skin integrity, which flourishes the nursing profession. However, several factors limit nursing development and inhibit the flourishing of the nursing profession. Some of these factors include undervalue and lack of respect and recognition which adversely affect the social standing of the nursing profession, as illustrated in the findings (Chapter Four, Section: 4.2.3, pages: 156-158). Among healthcare professionals, nurses often face high levels of stress and emotional demands in their work, which can lead to burnout and feelings of exhaustion, detachment, and cynicism, as mentioned in Chapter Two (Section: 2.2.1.1, pages: 38). The finding also revealed that nurses are exhausted due to the impact of the pandemic of COVID-19 and even after the pandemic, the staff still suffering from increasing workload (Chapter Four, Section: 4.2.1, page:147-152; Section: 4.2.2, page: 153-156). Therefore, nursing shortages can significantly affect the flourishing of the profession and lead to high workloads and understaffing, which compromise the quality of healthcare. However, there are underlying factors that also affect the flourishing of the nursing profession as illustrated by the research findings such as organisational regulations and rules, lack of power or power dynamics, lack of career structure, and lack of trust in nursing knowledge. Therefore, with the existence of these challenges, nurses' motivation toward developing TVNs decreased (Chapter Four, Section: 4.5.2, pages: 182-184).

5.4. Inter-Departmental Factors

Building high-performing organisations requires understanding the factors that influence individual behaviours, organisational dynamics and inter-departmental factors. These factors play an important role in shaping organisational behaviour and culture (Chapter Two, Section: 2.3.5.1.1, page: 54; Section: 2.3.5.1.2, page: 55). It also refers to the relationships and interactions between different departments in the organisation and how they affect the overall performance and effectiveness of the organisation. The findings from Kuwait, Qatar, Jordan and Egypt clearly showed system inefficiencies, it is the gatekeeping that prevented the researcher from accessing nurses and the delay in data collection in Kuwait was the outcome of inefficiencies of the system (Chapter Three, Section: 3.5.2.1, page: 106). When departments

work together, they can share resources, expertise, knowledge and efficiently solve problems. However, the findings illustrate that some issues exist related to a lack of collaboration and teamwork between departments. If one department is busy then other departments avoid collaborating, also there are some internal issues and conflicts between nursing departments like personal grudges. For example, some nursing leaders have different priorities and personal preferences for some departments or staff (Chapter Four, Section: 4.4.1, pages: 174-175). This illustrated that the unpleasant working environment eventually affects nursing performance and inhibits their ability to progress in any area of speciality. Furthermore, inter-departmental relationships are influenced by power and politics in the organisation. The departments with more power or influence exert control over other departments, which leads to conflicts. The findings revealed that doctors are more powerful than nurses due to their hierarchical level in the organisations as discussed in Chapter Two (Section: 2.3.5.1, pages: 53-54). For example, doctors are always in leadership positions such as hospital directors, directors' deputies, assistant directors and heads of different departments. Hence, based on doctors' power and control, the hospital protocol and norms are developed. This includes designing the policy in a way that supports them always. Therefore, understanding the power dynamics and the impact of inter-departmental factors in organisations can help managers develop strategies to improve communication, collaboration, and conflict management, leading to better performance for nurses regarding wound management or any area of nursing care.

5.4.1. Conflict

Conflict in the workplace can be caused by a range of factors, including communication breakdowns, power imbalances, domination and competing priorities. Inter-departmental conflicts can arise when departments have competing priorities or different goals (Boutron et al., 2019). It can undermine a sense of achievement and satisfaction in work, leading to decreased motivation, reduced sense of purpose, and then decrease the efficiency of an individual's work (Chapter Two, Section: 2.2.1, pages: 38). The findings showed that nurses who are experiencing ongoing conflict with doctors are exposed to high levels of stress due to the administration's policy (Chapter Four, Section: 4.2.1, pages: 147-152). This supports Leiter (1991) arguments related to the consistencies of the professional role and professional duties leading to conflict (Chapter Two, Section: 2.2.1.1, page: 38). The findings also revealed there is a conflict between nurses and doctors, which is developed from their professional role. This conflict is related to their roles and responsibilities in dealing with wounds (Chapter Two, Section: 2.3.5, page: 50). Doctors are using nurses as a tool to do their tasks such as asking

nurses to write patient notes (Chapter Four, Section: 4.4, page: 170). Therefore, conflict highly affects nurses' performance and then eliminates nurses' ability to develop as TVNs.

5.4.2. Burnout

Organisational behaviour along with other factors can also contribute to increasing burnout rates in healthcare settings, including high workload, lack of support or being undervalued by the organisations (Dall'Ora et al., 2020). Also, verbal and physical violence, nurses shortage and increased workload all are leading factors to burnout (Chapter Two, Section: 2.2.1, page: 38). The findings illustrated that nurses are suffering from staff shortages in Kuwait, Qatar, Jordan and Egypt (Chapter Four, Section: 4.2.2, pages: 153-155; Section: 4.6.2.1, page: 191). However, the situation is more severe in Kuwait and Qatar, because both countries are relying significantly on foreign nurses who are coming mainly from India, Egypt and Jordan as explained in chapter two (Section: 2.10.3, page: 72; Section: 2.10.4, page: 74). The reliance on foreign nurses led to several nurses' resignations in Kuwait and Qatar as foreign nurses are seeking better working opportunities elsewhere in the world such as in Western countries. The finding showed that nurses are leaving their work in Qatar and Kuwait due to different issues as illustrated in Chapter Four (Section: 4.6.1; pages: 186-187, Section: 4.6.2, pages: 191; Section: 4.7, page: 194). The findings also illustrated that in Egypt and Jordan, nurses are leaving to work in Gulf countries such as Kuwait and Qatar. As discussed by Amarneh et al. (2021); El-Bahnasawy, Al Hadid and Fayed (2021), nurses are seeking work opportunities in Gulf countries for better salaries (Chapter Two, Section: 2.10.1, page: 70; Section: 2.10.2, page: 71). The finding illustrated that nurses were not satisfied with their work, and they were not keen to develop as speciality in tissue viability. Some respondents mentioned that nurse shortage and workload are negatively affecting their duties, when going back home they are exhausted and have no time to spend with their families (Chapter Four, Section: 4.2.2, page: 153). Addressing the leading factors of burnout can help to maintain nurses' well-being and then nurses can focus on developing specialised areas in nursing. To avoid nurse's burnout, the administration should make sure that the nurses are satisfied in their working environment by providing support and listening to them. Developing effective workforce planning to deal with the issue of staff shortage and recruiting additional staff or implementing better scheduling practices. However, the findings revealed there is ineffective planning, which leads nurses to seek other working opportunities (Chapter Four, Section: 4.6.1, pages: 186-187).

Nurses’ burnout can contribute to conflict in the workplace, as nurses who are experiencing burnout are more likely to become irritable or defensive leading individuals to become disengaged from their work and less invested in the outcomes of their interactions with colleagues which contributes to conflict and vice versa. Burnout and conflict are two issues that adversely affect the development of new nursing specialities such as TVNs. Because nurses are demotivated to pursue professional development programmes and training related to wound management. Therefore, nurses’ burnout and conflict interfere with nursing flourishing, then lead to resistance to nursing professionalisation.

5.5. Toward Nursing Professionalisation

Professionalisation refers to the process of establishing the profession, through developing the specialised knowledge, skills and standards for education and training to improve the status and practice of the profession (Chapter Two, Section: 2.2, page:36). Therefore, this research used a professionalisation framework to understand the absence of TVNs in Kuwait, Qatar, Jordan and Egypt, as well as understand the development of the nursing profession in the named countries. This section provides a detailed discussion of the research findings including the organisational, cultural and social issues that impact the development of the profession.

This research argued that applying a professionalisation framework can elevate the nursing status and provide an essential element to enable nurses to produce knowledge and make decisions. By providing a comprehensive education and training programme to change nurses' roles related to wound management. This process of professionalisation encompasses decision-makers' support to advocate for TVNs, through developing a nursing curriculum, facilitating internal and external training and providing equal professional development opportunities for nurses. The findings from the literature review explored a substantial investment in the healthcare system in Kuwait and Qatar. In both countries, the government aims to develop the health system and improve the medical facilities by developing massive and new hospitals applying accreditation and quality programmes from Canada (Chapter One, Section: 1.7.1.1, page: 19; Section: 1.7.21, page: 25, Section:1.8, page:30). These hospitals were extremely symbolic of progression and development, despite that, less consideration was given to improving the contextual factors and challenges such as nurses’ shortage, increased work demands, lack of career structure, further organisational, social, and cultural barriers. The

findings from Kuwait, Qatar, Jordan and Egypt illustrated that the development of health policies is significantly influenced by political interest and the exercise of power. The agenda and priorities of the policies are determined based on the decision-makers and stakeholders' interests while neglecting other aspects of staff development or solving the issue of staff shortage and exhaustion (Chapter Four, Sections: 4.2.1, 4.2.2 and 4.2.3, pages: 147-156).

The decision-makers view things differently; hence, their priorities are developed to achieve certain targets. In Kuwait, the Ministry of Health (MOH) vision aims to improve infrastructure development and invest in developing more hospitals and clinics by 2035 (Salman et al., 2020). However, the finding illustrated that there is a lack of human resources investments and there is negligence towards nurses' issues such as nurse shortage, workload, or professional development. Similarly, the Ministry of Health in Qatar aims to improve the quality of the healthcare services in the country (Elsayed, Abdullah and Aboulsoud, 2018). There is a focus on nurses' training and professional development, however, the finding illustrated less consideration was given to other issues of staff shortages and increased workload (Chapter Four, Section: 4.6.1.1. pages:188-190). It implies that the decision-makers focus on infrastructure development by building magnificent hospitals with advanced technology, with less consideration for human resources development. In contrast, in Jordan and Egypt, the findings showed there is an unremarkable investment in health facilities and the nursing profession (Chapter Four, Section: 4.2.4, pages: 159-160). Also, like Kuwait and Qatar, there is a nurse shortage and a high workload for nurses in Jordan and Egypt. This research revealed that the nursing profession is not the priority of decision-makers, there are some aspects related to the healthcare system structure and power dynamic, where nurses are considered as a female profession (Chapter Two, Section: 2.3.3.1, page: 44). Therefore, less consideration was given to the profession based on gender, cultural and social aspects, such as the community's perception of the profession as socially with low status (Chapter Two, Section: 2.3.3, pages: 43-44). This negligence is an ongoing issue, associated with the nurse's silence and fear as mentioned in (Section: 5.2.1, page: 200). This is further illustrated in Figure 5.5. The findings of this research illustrated that nurses suffer from different issues such as low salary, lack of flexibility in immigration visas, gender discrimination, lack of professional development opportunities and lack of power. However, there are no significant actions taken by the decision-makers to deal with nurses' issues. This indicates that the nursing profession is not the top priority of the decision-makers in Kuwait, Qatar, Jordan and Egypt. All these issues adversely affect nurses' ability to proceed with their career development. This leads to decreased staff

motivation to learn new knowledge related to wound management or change their current role or practice in wound management. These issues have been discussed in three main themes: inability to exercise nurses' own knowledge, power and authority and culture influence as will be explained accordingly in this chapter.

Figure 5.5: Associated Issues with Nurse's Silence

5.5.1. Inability to Exercise Nurses' own Knowledge

5.5.1.1 Lack of Trust in Nurses' Knowledge

Appropriate skin care is essential for maintaining skin integrity, preventing skin damage and enhancing the well-being of patients. Skin integrity and wound management are essential factors of nursing practice as mentioned in chapter two (Section: 2.6, page: 60). Furthermore, nurses play a critical role in promoting and maintaining wound healing and restoring skin health (Chapter One, Section: 1.5, page: 10). This research explored that Kuwait, Qatar, Jordan and Egypt; developed quality programmes to improve overall patient care as well as improve the organisation's outcome (Chapter One, Section: 1.8, page: 30). According to Lichterfeld-Kottner et al. (2020), maintaining a healthy skin condition is an integral part of nursing practice; therefore, skin integrity is considered as a quality indicator for nursing care (Seaton, Cant and Trip, 2020) Chapter One, Section: 1.8, page: 30. Further, improving skin integrity and in particular pressure ulcer incidence are considered a main quality indicator in

the UK and Europe and it is part of the harm-free agenda. Conversely, the findings from Kuwait, Qatar, Jordan and Egypt revealed that there is a lack of knowledge of advanced nurses' practice in wound management and skin integrity (Chapter Four, Section: 4.3.1, page: 167). Also, there is a lack of awareness about wound care or management, whereas the participants clearly stated the policy focuses on quality and safety programmes or patient care instead of wound management (Chapter Four, Section: 4.2.1, page: 147). Although, wound care is an integral part of nursing care. Undoubtedly, nursing roles and responsibilities focus on promoting health and maintaining a healthy life for individuals. Therefore, if patients have chronic wounds and poor skin conditions this will adversely affect patients physically and psychologically. The relationship between wound care and the overall well-being of a patient is given in Figure 5.6.

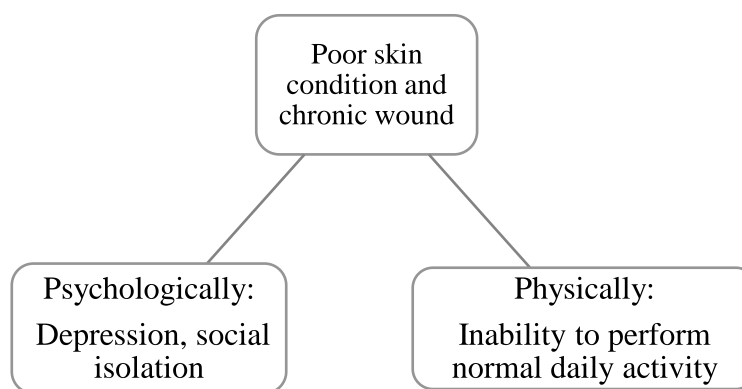


Figure 5.6: Impact of Poor Skin Conditions on Patients

Nursing professionalisation, skin integrity and wound management are interlinked, further with increasing professionalisation leading to greater recognition of the importance of specialised knowledge and skills in wound management (Chapter Two, Section: 2.2, page: 36; Section: 2.3.2, page: 42). Professionalisation enhances the scope of nurse's knowledge, which builds trust in the nurse's practice (Freidson, 2001; Saarikoski et al., 2018), Chapter Two, Section: 2.8, page: 65. This has led to increasing nursing recognition as a distinct profession with unique knowledge and skills in wound management and well-equipped to provide effective care to patients with complicated wounds, including pressure ulcers, diabetic foot, surgical wounds and traumatic wounds. Therefore, developing TVNs in Kuwait, Qatar, Jordan and Egypt is important. The research findings illustrated that there is a lack of awareness of TVNs and their role, further, the job titles of TVNs are poorly understood by the nurses

themselves (Chapter Four, Section: 4.3.1, page: 167). This supports the arguments of Ousey et al. (2015) about the lack of standard recognition for the TVNs job descriptions and the ambiguity of their job title and roles leads them to be internationally not acknowledged by some countries. Also, White (2008), argued that the scope of practice for the TVNs was not broadly accepted outside the nursing scope (Chapter Two, Section: 2.6, pages: 60). This explains the absence of TVNs in Kuwait, Jordan, and Egypt. In the case of Qatar, the TVNs are available only in one main governmental organisation (Hamad Medical Corporation) and private sectors. The availability of TVNs in Kuwait, Qatar, Jordan, and Egypt is explained in Table 5.1.

Table: 5.1: Existence of Tissue Viability Nurses (TVNs) in Kuwait, Qatar, Jordan Egypt

No	Country	Government	Private
1.	Kuwait	-	-
2.	Qatar	X	X
3.	Jordan	-	X
4.	Egypt	-	X

It is important to include skin care and assessment training programmes for healthcare professionals (Bonifant and Holloway, 2019). These programmes and training required resources such as financial resources which could be affordable in some countries, due to government financial support. It also required human resources (sufficient staff) to provide internal and external training, without affecting the health services and patient care. The World Health Organisation report (2015) underlined that there is a lack of training for nursing in Kuwait (Chapter Two, Section: 2.3.1, page: 40). The finding from Kuwait showed that nurses are receiving basic training, related to dressing and cleaning wounds. Similarly, in Jordan and Egypt, there is a lack of comprehensive training related to wound management (Chapter Four, Section: 4.2.2, page: 153). This illustrates that the nurses in Kuwait, Jordan and Egypt lack comprehensive knowledge related to wounds and skin integrity. The training that the staff are gaining did not add new knowledge regarding wound management such as the usage of technology to enhance the healing process or dealing with chronic and complicated wounds. On the other hand, the respondents from Qatar illustrated that they are receiving intensive training related to wound management which is delivered by specialist nurses in tissue viability. This includes the latest items and devices that are used to facilitate the wound healing

process. Several professional organisations provide resources and training opportunities for nurses to improve their knowledge and skills in the area of wound management. Yet, the findings from Kuwait, Jordan, Qatar and Egypt showed that the nursing profession is not well accepted by patients and healthcare providers as a knowledge producer. There is also a lack of trust in nursing knowledge due to the domination issues and gender inequalities as will be explained later (Chapter Four, Section: 4.3.2, page: 168). In regard to the nursing profession, this research revealed that there is a lack of understanding of the nurse's role and practice, which leads to a lack of trust in the nursing profession in Kuwait, Qatar, Jordan and Egypt. This lack of trust developed because the nursing profession is a junior profession as it started between 1950 to 1960 in Kuwait, Qatar, Jordan and Egypt (Figure 5.7), through the development of nursing schools (Chapter One, Table 1.1, page: 13). Although, in Egypt and Jordan, there are several nursing colleges and higher nursing degree programmes such as Master's and Doctorate degrees. On the other hand, higher degree programmes are absent such as Master's or Doctorate degrees in Kuwait (Chapter Two, Section: 2.8, page: 65). In Qatar, nursing started a few years after Kuwait. Despite that, Qatar has established several nursing programmes including Master's degrees and more professional development programmes and training (Chapter Two, Section: 2.10.3, page: 72). Inspite of that, the findings from this research illustrated that the qualification level of nursing varies between Kuwait, Qatar, Jordan and Egypt such as Kuwait offers bachelor and diploma whereas Egypt and Jordan offer Master's and PhD. However, the challenges associated with the nursing profession are quite similar in those countries, like a lack of trust in nurses' knowledge and the low social status of nurses regardless of their qualifications. Nurses could have higher degrees but lack the skills to deal efficiently with skin ulcers (Saleh et al., 2019), Chapter Two, Section: 2.8, page: 65.

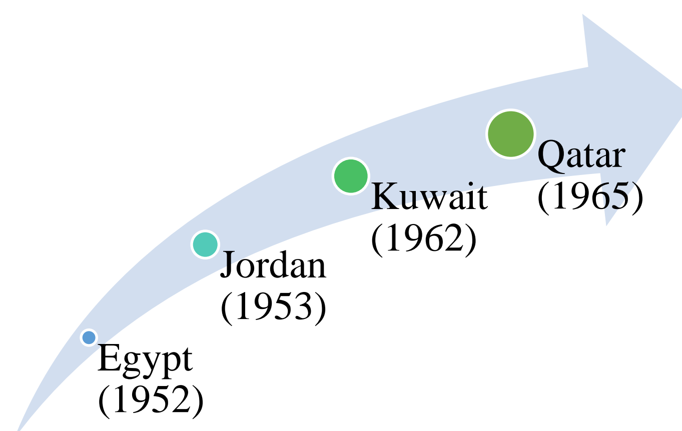


Figure 5.7: Nursing profession in Kuwait, Qatar, Egypt and Jordan

Several issues lead to a lack of trust in the nursing profession, due to the organisational aspects such as power and authority and cultural influences. Also, the role of the media adversely influenced the nursing profession (Chapter Two, Section: 2.9, pages: 66). Nurses have low social status because of the way the media usually presents nurses negatively without considering nurses' knowledge and skills and their contribution to the health service. Therefore, the issue is beyond trust, it is related to cultural and social aspects which develop the community's perception and behaviour about the nursing profession. Focusing on the social construction of the professionalisation of nursing can enable to understand the determinants underlying the lack of nursing development. Therefore, the role of social constructivism in this regard is to help in exploring the social forces surrounding a social phenomenon, these forces tend to occur in the form of behaviour and response towards nursing, which can undermine the profession hence its development. As nursing professionalisation continues to evolve, there is increasing emphasis on the importance of specialised knowledge and skills in specific areas of nursing practice, such as wound management. This implies that knowledge and skill are essential to the nursing profession. Yet, nurses are not able to exercise their knowledge related to patient care. For example, doctors are not accepting nurses to engage in health decisions. This can lead to other factors such as cultural influences and power dynamics which affect the organisation's hierarchy of power, as will be explained next.

5.5.2. Power and Authority

The ability of an individual or group to influence others and make decisions related to the system is known as power (Parvin, 2022). In the health system and working place, power is organised according to different levels in the organisational hierarchy, it could be visible, invisible, or hidden power (Gaventa, 2006; McKee, Steele and Stuckler, 2019), Chapter Two, Section: 2.3.5, page: 50. On the other hand, individuals' right or legitimacy to exercise their power within the system or organisation is known as the authority (Ohrling et al., 2022)**.** Power tends to be legal and formal, whereas authority can be more informal, and status based. For example, in the UK the government in parliament has the legal power constitutionally but the King still wields authority without legal power which makes him very influential. Macheridis and Paulsson (2019) stated that any profession has the power to make the decision. From a professional perspective, the existence of power is essential to enable nurses to develop new policies or to change the current ones, to update the standards of care related to wound

management or different aspects of care. Bourgault and Parent (2008) and Hampton et al. (2009) highlighted that professional knowledge and skills related to the career are transferred to principles that guide the employees in decision-making. Such as ethical principles and professional values and norms. Profession then enhances the nurse's power, this power is essential for any profession when it comes to self-satisfaction, decision-making and organisational change. Despite that, the findings showed that nurses do not have the power, and they are not able to make decisions related to wound management or other aspects of care.

The main role of TVNs is making decisions related to chronic and complicated wounds and skin conditions, hence, nurses need the power and the authority to influence and make clinical and administrative decisions, which they do not have (Chapter Four, Section 4.2, page: 146). Therefore, the findings in this research support the arguments made by Traulsen and Bissel (2004); Oberhuemer (2015) and Aukett (2017) regarding nursing's limited power to influence other health professionals. In order to gain power, nurses need to have the knowledge and the capacity to exercise this knowledge. Consequently, acquiring knowledge requires intensive training and sacrifice as part of the professional role (Section: 5.3, page: 205). The finding illustrated that nurses are suffering due to staff shortages and increased workloads, alongside, nurses need to allocate spare time for attending workshops and training programmes. However, they cannot afford spare time due to the impact of COVID-19 on their current working circumstance and increase their work (Chapter Four, Section: 4.2.1, pages: 147-152; Section: 4.2.2, page: 153). Hence, the findings from this research support the arguments of Traulsen and Bissel (2004) and Aukett (2017) that professional duties are associated with responsibilities, self-sacrifice, and limitation. (Chapter Two, Section: 2.3.3, page: 43). The findings from Kuwait, Qatar, Jordan, and Egypt indicate that nurses lack the power of specific knowledge related to the wound healing process and dealing with chronic wounds (Section: 5.5.1, page: 211). Besides, nurses lack the authority to make decisions regarding wound management and other aspects of patient care the aspects are highlighted in Figure 5.8. This supported what was explored in chapter two (Section: 2.3.5, pages: 50-52). Further, the findings supported the argument of Hampton et al. (2009) and Pac et al. (2010) that the level of power, authority and decision-making are varied among professions (Chapter Four, Section: 4.3, pages: 161-166). Therefore, medicine as a profession has the power and authority to make decisions whereas nurses do not. The research findings revealed that the professional status of the medicine and their level in the organisational hierarchy helped to gain this power and authority and enable them to make decisions.

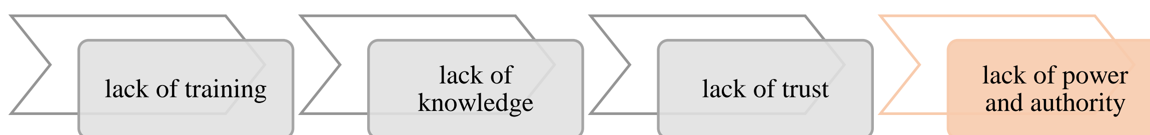


Figure 5.8: Leading Key Factors for Lack of Nurses' Power and Authority

The role of nursing leaders is important to develop TVNs. According to Carragher and Gormley (2017), it is important to have a nursing director to facilitate effective changes in nurses' roles (Chapter Two, Section: 2.4, page: 58). Also, Jabbar and Hussein (2017) stated that providing a strategic direction with leadership support is important to ensure the effectiveness of change. However, the finding illustrated that even nurse leaders in Kuwait, Qatar, Jordan, and Egypt have a limited level of authority to manage nurses' assignments and scheduling. For example, nurses' directors and those in managerial positions were not able to change the policy's direction or influence the decisions related to patient care. This is a barrier to changing nurse's roles and achieving an appropriate nursing practice related to skin integrity and wound management (Gethin et al., 2020). The findings of this research indicated that there is a contradiction between nursing decisions and policies, the decisions and policies are controlled by the organisation's management and doctors. This indicates that the doctors own the power in the health organisations, and they use this power for their benefit. Therefore, this research revealed that nurses do not have the power and the authority to advocate for their rights and priorities as they are unable to exercise their role freely in decision-making related to wound management. Even nurse leaders have a certain level of power to manage nurses' duties and scheduling, but they lack the authority to make decisions (administration/clinical). This manifests that power and authority are linked concepts that can advocate for new approaches in wound management, by shaping the direction of the nursing profession and facilitating change in nurses' roles. From that perspective, the findings of this research lead to different issues as depicted in Figure 5.9.

Figure 5.9: Issues Associated with Research Themes

5.5.2.1 Conflict of Interest

A conflict of interest occurs when a person or organisation has different needs, goals, competing interests, loyalties or responsibilities that may affect their ability to make objective, impartial and fair decisions (Field and Lo, 2009; Radun, 2021), Chapter Two, Section: 2.2.1.2 and 2.3.4.1, pages: 39 and 47; Chapter Four, Section: 4.2.1, page: 147. In a conflict situation, domination can occur when one party has significantly more power or influence than the other, and they can use that power to control or dictate the terms of the conflict resolution in their favour (Burnett and Lloyd, 2020). This can lead to an unequal outcome and a power imbalance between the parties involved, as each seeks to gain an advantage or achieve their goals at the expense of the other. The consequences of conflicts of interest in healthcare can be significant, including compromised patient care, unnecessary procedures or treatments and increased healthcare costs. Conflict of interest can be a professional relationship with individuals or companies that can influence their clinical decision-making. Therefore, doctors do not accept the nurse's influences in decision making which could lead to losing this interest. The findings from Kuwait, Qatar, Jordan, and Egypt illustrated that doctors are not willing to accept any thought or recommendation related to a patient's condition from nurses or other healthcare professionals (Chapter Four, Section: 4.4, pages: 170). Management needs to mitigate conflicts of interest and enforce conflict of interest policies to ensure maintaining transparency, fairness and accountability in their decision-making processes and operations. The conflict of interest policies are particularly important as they can have significant implications on wound management and the trust of the nurses. However, this research illustrated that policies do not exist in Kuwait, Qatar, Jordan, and Egypt, and in case they exist it is controlled by the decision makers (Section: 5.5.2, page: 215). Therefore, developing policies in this case would not solve any issues.

5.5.2.1.1. Truth About Policy

The power of policy in shaping the profession and reforming the responsibilities to employees has been described vigorously in several ways. In this context, Evans (2008) stated that professionalisation has been associated with management, it also provides a great opportunity for individuals to work effectively within the regulations, even with the existence of some challenges. Also, Miller and Rose (1990) and Maristany et al. (2023) considered professionalisation as a force of control (Chapter Two, Section: 2.2, page: 36). This means that professionalisation is used to control employees in several ways; through guidelines or policies

which could encompass challenges. Nevertheless, this research revealed that the policy was used to control individuals instead of improvement (Section: 5.2.2, pages: 202). This supports the arguments of Steelman and Ascher (1997) regarding the policy which could lead to individual stress (Chapter Two, Section: 2.3.4, page: 47). This implies that the policy is designed according to the decision-maker's interest, which is clearly used to control and limit nurses' ability to progress and further constrain their scope of practice. Some healthcare professionals like doctors can see nurses as a threat, for example, when the awareness of nurses' responsibilities increases. This enables nurses to perform their duties only instead of doing handmaiden jobs for doctors (Chapter Four, Section: 4.2.1, page: 147). Hence, doctors are maintaining the status quo by keeping hegemony on decision-making.

The findings from this research also revealed that there is confusion or mismatching about the policy and guidelines and there is a lack of awareness regarding the policies. This gives two thoughts, firstly, the policies that the participants are referring to do not exist in Kuwait, Qatar, Jordan, and Egypt; because there is no clear response about it. Secondly, the policies that participants are referred to, are possibly developed by the Ministry of Health in Kuwait, Qatar, Jordan, and Egypt, through the decision-makers and stakeholders without nursing involvement. The influence of the decision makers and stakeholders in developing these policies makes it powerful because it is coming directly from the Ministries of Health in the respective countries. Hence, it is used to control nurses and limit their role to following doctors' instructions only, along with performing basic nursing tasks, such as giving medication and monitoring vital signs. Hence, this research revealed that the policies are not supporting nurses in the organisations. For example, as per the policies, the nurse's role in Kuwait, Qatar, Jordan and Egypt is to assist doctors. In other words, if doctors fail to perform their responsibilities efficiently toward patients, the nurses used to be blamed (Chapter Four, Section: 4.2.1, pages: 147-152; Section: 4.4, pages: 170-173). Further, the literature review explored that the responsibilities and role of nurses have been defined based on the convenience of the decision makers and doctors (Chapter Two, Section: 2.3.6, page: 57). This indicates that the doctors used policies as a force to control nurses, and nurses were used as tools to protect doctors or to perform their tasks. Moreover, this research illustrated that policies are used as professional boundaries that restrict nurses' roles related to wound management and decision-making. This shows something deeper related to the organisation's structure and individuals' behaviour and attitude toward a policy where there is a belief the policy increases nurses' work in Kuwait, Qatar, Jordan, and Egypt (Chapter Four, Section: 4.2.1, pages: 147-152). The

attitudes and beliefs that policy increases nurses' work can adversely affect the development of TVNs and wound management. For example, if there is a new policy associated with a new speciality, nurses might not follow it, leading to inconsistencies in care.

5.5.2.2 Domination

5.5.2.2.1. Gender Domination

Within common values, norms and goals there can be a hidden aspect such as domination (Nombela, 2014; Burnett and Lloyd, 2020), Chapter Two, Section: 2.3.3.1, page: 44. This is often the case when the dominant group or individual in a society or organisation uses their power to influence and shape the values, norms and goals to serve their interests (*ibid*). Thompson (2018) stated that domination is a social power that shapes individuals' values that are used to orient their thoughts about legitimate authority and forms of obligation. This can be easily seen in the form of social inequality in distributing power in any society or in organisational hierarchically, such as: distributing social status, wealth and resources (Chapter Two, Section: 2.3.3, page: 43). In a workplace where the dominant group is predominantly male (Nombela, 2014), the values, norms and goals of the organisation may reflect a male-centric perspective, which lead women feeling marginalised and excluded (Bourdieu, 2001; Thompson, 2018). Similarly, in a society where one racial group is dominant, the values, norms and goals of that society may reflect the dominant group's perspective, leading to discrimination and inequality for minority groups including females. The finding shows that the policy supports male nurses in terms of flexibility to work in special departments with more allowances, such as operation theatre and intensive care units, where more professional development opportunities such as attending accredited conferences and promotions. The literature review explored that some political parties do not support female independence and consider females as a threat to their political positions (Tétreault and Al-Mughni, 1995; Tétreault, 2001; Al-Sabah, 2013). Nombela (2014) highlighted that management and leadership positions are usually carried by males. Inspite of that, Al Sabah et al. (2019) stated that females in Kuwait are experiencing a transition role in leadership positions, further female possibilities to lead the departments increased and become equal to males (Chapter Two, Section: 2.3.3.1, page: 44). However, this research revealed even females in leadership positions have limited power in managing nursing duties or scheduling and they have no authority to make decisions because of gender inequalities and patriarchal issues.

5.5.2.2.1.1. ***Gender Inequalities***

Gender inequalities and culture can have a significant impact on the development of the professions such as limited access to education and male dominance in certain jobs. Women have limited access to education compared to men and that has been noticed in different countries with different cultural backgrounds (Ballenger, 2010). This limits females' ability to pursue certain professions and results in a gender imbalance in certain fields. Cultural expectations and stereotypes can also shape which professions are seen as suitable for men or women (Wingfield, 2009). For example, nursing is often seen as a predominantly female profession as explored in chapter two (Section: 2.7, page: 64), and gender biases can impact the development of the profession. Therefore, the feminisation of nursing leads to several issues, especially in Middle Eastern countries such as Kuwait, Qatar, Jordan and Egypt for example, lower professional status, lack of respect for the profession and violence, which reflects gender bias. Therefore, cultural biases influence women's selection and stereotyping for certain professions such as nursing as explored in the literature review (Section: 2.3.3.1, page: 44). Similarly, the findings illustrate that male nurses are a minority compared to female nurses and socially there is lack of acceptance for the profession. However, the organisational culture and the system support male nurses, by providing more mentorship and scholarship programmes or other professional development opportunities, further fewer chances to face verbal or physical violence (Chapter Two, Section: 2.9, page: 66 and Chapter Four, Sections: 4.6.2.1 and 4.6.2.2, pages: 191-193). Workforce planning is also influenced by gender inequalities in Kuwait, Qatar and Jordan, Egypt (Chapter Two, Section: 2.11.2, page: 80). For example, unequal wages and unsupportive family visa policy. Women in general might not have access to the same support system as men, despite having the same level of training and skills. Therefore, the research findings reflect issues of gender bias, where the voices of female nurses are not heard as loudly as male nurses. Even the policymakers are male, hence, the policy that is developed would be in their favour as male. This is particularly challenging in professional development, further, making it harder for women to professionally develop as a speciality in tissue viability or any other speciality.

5.5.2.2.1.2. Professions and Patriarchy

Concerning gender and professionalisation, female roles and responsibilities at home related to providing care for family and children, were reflected in the selection of professions such as nursing and midwifery. The role of gender in the social system is referred to as

patriarchy, it is related to the patterns of male dominance in society and the unequal distribution of power within the family (Witz, 2013). Patriarchy focuses on the gender relations of male domination and females as subordinates (Hartmann, 1981; Walby, 1989; Cockburn, 1981), Chapter Two, Section: 2.8, page: 65. In relation to the profession, patriarchal culture has also influenced the distribution of gender according to the profession (*ibid*). The nature of some professions developed in human psychology and beliefs. For example, nursing is considered a female career, as females usually provide care for family members and children. However, nursing as a profession has different areas and departments where male nurses can fit in. Further, this research explored that male nurses have priority in being in leadership positions (Chapter Two, Section: 2.3.3.1, 2.3.3.2 pages: 44-46). In a patriarchal culture, female nurses face many challenges and more cynicism from patients who are uncomfortable receiving care from a female, this is influenced by cultural attitudes and behaviour toward female nurses. In some cases, female nurses could be subjected to harassment and other kinds of verbal and physical violence in their working environment from patients or their relatives, as revealed in the findings from Kuwait, Qatar, Jordan, and Egypt (Chapter Four, Section: 4.6.2.1, pages: 191-192). This was also explored in the literature review related to gender bias and violence (Kabbash and El-Sallamy, 2019; Elbarazi et al., 2017), Chapter Two, Section: 2.8, page: 65. Patriarchy significantly impacts females in the nursing profession by shaping gender roles based on cultural norms and expectations. For example, prioritising the roles according to gender and the role in the family such as the father and brother in Arab society are always responsible for leading the home, whereas the mother and sister role is limited to providing care and doing home duties (Joseph, 1996). This makes it challenging for women to pursue leadership positions, which are often seen as more appropriate for men.

Historically leadership positions are dominated by men, while women have faced various challenges and barriers to accessing leadership positions (Section: 5.5.2.2.1, page: 220). For example, professions that required positions of power and leadership were traditionally inaccessible for females due to the patriarchal structures and societal norms. The underlying reason for undermining the nursing profession is that nursing is a generally feminist profession. Further, in the patriarchal culture females do not have system support. The finding also illustrates that the nursing profession in Kuwait, Qatar, Jordan, and Egypt is considered socially lower than doctors. This supports the arguments of Adams and Miller (2001) and Meerabeau (2005) that nursing is considered a semi-professional career (Chapters Two, Section: 2.8, page: 65). This perception of nursing as a semi-professional is rooted in a

patriarchal culture and extended to different aspects such as the role of nursing in supporting medicine. The level of nurses within the hierarchical structures of the organisation is always below doctors (Chapter Two, Section: 2.3.5.1, pages: 53). Therefore, professions and patriarchy have a significant relationship that has evolved over time. The findings from Kuwait, Qatar, Jordan, and Egypt showed that there are pay disparities and biases in professional development opportunities and hiring practices. Which also reflects male and professional dominance in Kuwait, Qatar, Jordan, and Egypt. Also, in a patriarchal culture, females face several barriers at higher levels of leadership and decision-making, for example, unsupportive policies for nurses, or unsupportive leadership. This highlights the complexity of the system and power dynamics that affect female opportunities in professions. For example, developing TVNs requires attending conferences and workshops, whereas females have limited access to education and professional development opportunities, especially outside the country, due to cultural restrictions and norms of the societies in Kuwait, Qatar, Jordan, and Egypt; as females cannot travel without a parent or a male guardian. This limitation in education and professional development is also a barrier for females to progress professionally which is the effect of patriarchy. Therefore, patriarchy adversely affects the development of TVNs in Kuwait, Qatar, Jordan, and Egypt. According to Witz (2013) and Adisa, Abdulraheem, and Isiaka (2019), gender patriarchy and race are dominant in the Western model, and they are also transposed into the Middle Eastern model, such as men are dominant and women are subordinate to them; this includes the dominate roles of men in leadership and social privilege. This explains the stereotyping, the selection of the profession, and the relationship between gender and professionalisation. Therefore, gender inequalities and patriarchal culture can significantly affect the development of TVNs, further limit the available opportunities to individuals in certain professions, and lead to an uneven distribution of talent across different professions. As a result, nurses cannot generate a particular knowledge regarding wound management and even if they have the capacity to do so, it is difficult to trust their ability to develop knowledge in wound management, which is the main barrier to professional development.

5.5.2.2.2. Profession Domination

Domination is a social behaviour that arose and is rooted in the health organisation. It is associated with other social behaviours and actions such as superiority, conflict, or competition. Professional domination can be seen in a variety of contexts such as in education and training. It can lead to unequal decisions, limited opportunities for career advancement, and discriminatory policies. This research finding supports O'Shea, Boaz and Chambers (2019)

statement that power status and dynamics influence the healthcare system, further shaping the way that individuals perceive things such as doctor domination and nurses' obedience. (Chapter Two, Section 2.3.5.1, page: 53; Chapter Four, Section: 4.3, pages: 161-166). The issue of domination predominantly affects the nursing profession. The finding of this research explores that doctors as professionals are dominant and they are considered superior to nurses; superior in terms of social status and their qualifications deemed to be superior. In addition, their role in social well-being (serving social and individual needs) is considered integral. Doctors' supremacy and domination have been developed in the mindset of the nurses. For example, doctors' behaviours in dealing with nurses is controlled by invisible power such as the status quo (Chapter Two, Section: 2.3.5, page: 50). Doctors are the ones making clinical and administrative decisions, further some doctors use nurses as a tool to perform their task, as revealed from the findings (Chapter Two, Section: 2.3.6, page: 57; Chapter Four, Section: 4.4 pages: 170 and 173). Respondents from Kuwait, Qatar, Jordan, and Egypt illustrated that their role is to assist doctors (Chapter Four, Section: 4.3, page: 161). According to Johnson (1996), domination can be seen in preserving the knowledge for some groups where only individuals within that group can use this knowledge. He also describes this knowledge as dark knowledge, which is the outcome of power domination and control. This explains why doctors are dominant, for example, in order to maintain the status quo, doctors perceive the knowledge of wound management for themself and avoid sharing their knowledge with nurses. Consequently, nurses would always be relying on doctors for decision-making (Chapter Four, Sections: 4.3, page: 161; Section: 4.3.2, pages: 168-169). Hence, this leads to the deskilling of the nursing profession and prevents them from progressing.

The findings of this research revealed that the policy supports doctors in decision-making due to their high level in the organisational hierarchy and their social status. Also, the respondents expressed that there are certain limitations in their role in the organisation, such as a lack of involvement in decision-making. The participants' behaviour and actions are controlled by an invisible power such as cultural influence, tradition, and norms. For example, the way that nurses think and believe shapes their behaviour and practice toward wound management, such as following doctors' instructions without discussing it with doctors. However, TVNs are leading doctors and other health professionals to effective change as explored in Chapter One (Section: 1.2, page: 6). Hence, doctors' dominations and behaviours toward nurses can lead to unacceptance of the TVNs role. Therefore, this research revealed that the issues of domination are prominent in Kuwait, Qatar, Jordan and Egypt, and nurses are

afraid to change this system (Chapter Four, Section: 4.3.2, page: 168). Creswell and Poth (2018) highlighted that in the organisation, individuals could face some professional challenges related to domination and suppression. This indicates the impact of domination on the nursing role, which is an obstacle to nursing professionalisation and to the development of TVNs in Kuwait, Qatar, Jordan, and Egypt. Addressing professional domination is particularly challenging because it is deeply embedded in the structures and practices of a profession.

Therefore, to avoid domination between doctors and nurses, it is important to encourage diversity in decision-making processes and to actively seek out and amplify the voices of nurses by engaging them in open communication with doctors and seeking a mutually acceptable solution that takes into account the needs and perspectives of nurses and doctors. This can help to create more equitable and sustainable outcomes and can prevent the extension of power imbalances and domination. In this context, this research uses Transformative Frameworks to change the current practice and belief in the organisation (Chapter Three, Section: 3.3.2, page: 94). Moreover, adopting certain transformative criteria to address social issues such as gender inequalities and then apply transformative frameworks to facilitate social change related to these issues. This social change in nursing practice can be associated with challenges such as organisational and cultural challenges as explored in the literature review (Chapter Two, Section*:* 2.3.5.1.1, page: 54; Section: 2.3.5.1.2, page: 55). Therefore, this research findings would be delivered to the policymakers and management for their actions. For example, management must maintain the transparency of the policy development, by conducting a committee from multidisciplinary teams and including nurses' leaders in decision-making to ensure that policy is fair to all healthcare personnel and not supporting one party against others. This can help to ensure that the organisation's goal and objectives are reflective of the needs and perspectives of all members, rather than just those of the dominant group. In addition, addressing these attitudes and beliefs through changing the social structure and professional dynamic, along with education and training can help to transform a nurse's role regarding wound management. In addition, the issue of domination could also lead to path dependency.

5.5.2.3. Path Dependency

Apart from domination, the findings explored the issue of path dependency which refers to the current state of a system that is influenced by history and decisions that have been made in the past, that could be difficult to deviate from this path into the future (Barnes, Gartland and Stack, 2004; Kay, 2005), Chapter Two, Section: 2.3.1, page: 40 and Chapter Four Section:

4.4, page: 170. This is relatively similar to the domination issues, in which doctors are dominant and it is challenging for nurses to change this path and develop a new speciality in tissue viability. As previously mentioned, any change is associated with challenges and resistance. The history and background of the nursing profession might inhibit the development of new approaches or standards of care related to wound management. For example, doctors do not accept nurses' involvement in decision-making regarding patients' care, because it never happened in the past and there is no benefit for them to change this path and to accept nurses' involvement in decision-making. Also, the findings from Kuwait, Qatar, Jordan and Egypt; illustrated that nurses are not interested in discussing with doctors related to patient care (Chapter Four, Section: 4.3.2, page: 168; Section: 4.4, page: 170). Path dependency occurs when nurses continue to follow an old protocol or guidelines related to wound management, even with the existence of evidence that recommends some new approaches. This behaviour is associated with resistance (Chapter Two, Section: 2.2.1.2, page: 39). The findings revealed that participants are afraid and concerned about developing a new nursing speciality in tissue viability (Section: 5.2.1, page: 200), therefore, this fear can be developed in resistance to changing current practice, for example, fear of increasing their responsibilities and more workload. In regard to wound management, the findings revealed that nurses are following doctors' instructions only without discussing with doctors (Chapter Four, Section: 4.3, page: 161). Therefore, nurses are following the same path without changing because of the influence of the political power in the system in Kuwait, Qatar, Jordan and Egypt such as nepotism (Chapter Two, Section: 2.3.5.2, page: 56). For example, the findings revealed that the nursing profession is controlled by the decision-makers, therefore, there is fear of changing nurses' roles and those nurses would prefer to follow the same path instead of facing some consequences from the decision-makers (Chapter Four, Section: 4.2.3, pages: 156-159). The findings also illustrated that the participants were unaware of the role of TVNs which can explain their resistance to change and continue the current path due to uncertainty of the role of TVNs.

Path dependency also reflects some aspects of organisational culture and behaviour, as individuals prevent changing their practice (Chapter Two, Sections: 2.3.5.1.1; Section: 2.3.5.1.2, pages: 54-55). Therefore, to change the path dependency, it is important to consider organisational structure and behaviour. Sometimes organisational behaviour is rigid and does not accept new changes, due to the power of the system, which in this research refers to doctors. Path dependency encompasses employees' beliefs and behaviour to change this path according

to the organisational needs. The rigidity of organisation behaviour is associated with cultural aspects and beliefs, which are challenging to change. In this research, the findings illustrated that nurses are performing their duties without discussing or questioning doctors or even sharing their opinions or thoughts regarding patient care, which is an important element of the professionalisation of nurses. Therefore, there is a necessity to change the individual's behaviour and practice, by developing a new nursing approach through the lens of professionalisation to empower nurses in decision-making. Possibly through, improving nurses' status and enhancing nurses' engagement with the organisation's meetings and conferences to increase nurses' awareness of the new approach to care. Moreover, the issue of path dependency is a result of a rigid organisational culture in Kuwait, Qatar, Jordan, and Egypt.

5.5.2.4. Discrimination

TVNs are leading doctors and other professions for effective change by introducing new knowledge and new approaches to managing wounds as well as improving the wound healing process (Kellie et al., 2010; Ousey et al., 2015), Chapter One, Section: 1.2, page: 6. This means those nurses are leading doctors' decisions, but in this research, the finding showed that nurses in Kuwait, Qatar, Jordan and Egypt; were not able to make decisions related to wounds, which is the main role of the TVNs. Decision-making is an essential character of the profession (Chapter Two, Section: 2.2, page: 36; Section: 2.6, page: 60). The literature review explained that knowledge and making decisions are integral to any profession, hence, to maintain a healthy professional status, individuals need to have the knowledge and authority to make decisions. However, the research findings revealed that there is discrimination against nurses' knowledge (Section 5.5.1, page: 211), and this discrimination led to a lack of trust in nurses as a knowledge producer. This research illustrated the importance of wound management (Chapter One, Section: 1.3, page: 8; Chapter Five, Section: 5.5.1, page: 211). Despite that, the outcome of the findings illustrated that there is negligence and discrimination against the importance of wound management. Less importance was given to wound management and there is less initiative to develop this area, for example, there is a lack of training related to wound management and, further, limited research related to wound management and skin integrity. TVN is a relatively new nursing speciality that developed in 1980 in the UK (Chapter One, Section: 1.2, page: 6). The research findings illustrated there is discrimination against TVNs knowledge, for example, people believed that their role is limited to a wound dressing only, this showed there is a lack of awareness of TVNs (Chapter Four,

Section: 4.5.2, page: 182). Also, the literature review (Section: 2.11.4, page: 81) revealed there is discrimination about wound management, and they consider it an unpleasant job, where nurses are required to clean wounds and remove pus.

Further, this research revealed that nurses in Kuwait, Qatar, Jordan and Egypt are facing different kinds of discrimination such as discrimination against nurses as opposed to physicians. Physicians used nurses as a tool to do their tasks (Section: 5.5.2.2.2, page: 223). This shows that the doctors consider nurses, professionally, academically, and socially lower status than them, which reflects discrimination against the status of healthcare. The issues of discrimination against women both as leaders and providers of knowledge were clear from the findings (Chapter Four, Section: 4.4.2, page: 176; Section: 5.5.2.2.1, page: 220). The findings illustrated that the decision makers are male usually, so the policy is developed in their favour and does not support females in terms of wages and promotions. Additionally, the findings illustrated there is discrimination against foreign workers, for example, the immigration visa does not support females to bring their family or children (Chapter Four, Section: 4.6.1.1, page: 186). Most nurses in Kuwait and Qatar are foreign nurses and they are facing violence, however, even national people stated they face violence as explained in chapter four (Section: 4.6.2.1, page: 191). Therefore, the reason for the absence of TVNs and nursing specialisation in Kuwait, Qatar, Jordan, and Egypt is because of these issues of discrimination in the nursing profession.

5.5.3. Culture Influences

Organisational and cultural factors can have a significant impact on the development of the nursing profession. For example, inadequate staffing levels can lead to high turnover rates and burnout among nurses. This can make it hard to attract and retain qualified nurses and might result in a shortage of nurses in certain areas, hence, this shortage leads to staff exhaustion and then the inability to accept new changes in their role (Section: 5.4.2, page: 208). The culture of an organisation can have a significant impact on the development of the nursing profession in both positive and negative ways. For example, a positive culture that values teamwork and collaboration can lead to better job satisfaction. Besides, the use of technology in healthcare has had a significant impact on the nursing practice, especially in the area of wound management research, such as enabling nurses to access libraries for research purposes. Hence, organisations need to create a positive culture that values the contributions of nurses and invests in their professional development opportunities to develop their careers. Chapter

one explores that in Kuwait and Qatar, more chances are available for individuals to develop professionally, due to the government's support in both countries and investments in health facilities which can support the development of new departments for TVNs (Section: 1.7.1.1, page: 19, Section: 1.7.2.1, page: 25). However, the findings illustrate that nurses have limited access to cyberspace and there is a lack of nurses' engagement in the research and professional development programmes, which can hinder the development of TVNs in the respective countries.

The literature reviews also explored that culture has a significant influence on individuals' behaviours and attitudes, further shaping the way they think and interact with others. Hence, it guides individual actions and develops their values and beliefs (Spencer-Oatey and Franklin, 2012; Wagstaff and Burton-Wylie, 2018), Chapter Two, Section: 2.3.5.1.2, page: 55. In order to develop TVNs in Kuwait, Qatar, Egypt and Jordan, it is important to understand individuals' beliefs and concepts related to wound care and dealing with wounds. For example, cleaning wounds requires handling bodily fluids and removing the pus from the wounds which is considered an unpleasant job (Section: 5.5.2.4, page: 227). Although, dealing with wounds requires specific knowledge and skill, but nurses in the Middle East might consider it an unpleasant job. Therefore, understanding individuals' beliefs is important to deal with individuals' fear and resistance to the new speciality. Additionally, understanding the culture is important to know the relationship between doctors and nurses in the organisation. For example, how they interact and deal with each other (Chapter Four, Section: 4.4, page: 170). There is reinforcement about nurses' attitude toward change, which this research indicates that changing nurses' practice is challenging, especially with the influence of the culture and the background, on nurses' behaviour toward dealing with doctors. Also, it was obvious from the findings that doctors are not accepting nurses as a producers of knowledge because nurses recently developed academically (Lotan, 2019). Therefore, the finding from the interviews supports the arguments of Adams and Miller (2001) and Meerabeau (2005) as illustrated in Section: 5.5.2.2.1, page: 220. For example, nurses in Kuwait perform basic nursing care such as giving medication, checking vital signs and being considered as doctor assistants (Al-Kandari and Ogundeyin, 1998). This indicates that the nursing profession is significantly influenced by culture, individuals and community beliefs. This manifests that culture can have a significant influence on professional development, including individuals' values and beliefs that shape their work and the way that is structured and carried out. For example, the decision-makers in Kuwait, Qatar, Jordan and Egypt must take into account the cultural aspect while

planning to distribute nurses among different departments (Chapter Two, Section: 2.11.4, page: 81). From a professionalisation lens, developing TVNs requires an adequate number of male and female nurses to suit the traditions and norms in Kuwait, Qatar, Jordan and Egypt. However, this requires more nurses to provide efficient care for both male and female patients. Despite that, the literature review explored that male nurses are not interested in selecting nursing as a career (Section: 2.11.2., page: 80). In addition, the finding illustrated that nurses are exhausted due to staff shortage which also affects nursing professionalisation. The barriers toward professionalisation were similar to all participants regardless of their culture and background, which might create a barrier toward the specialisation of TVNs. Given the implication, that culture is a powerful force that can shape individuals' identities and beliefs in a particular profession in Kuwait, Qatar, Jordan and Egypt, this includes the following:

5.5.3.1 Institutional Inertia

The research finding illustrated that there is resistance to change (Section: 5.2.2, page: 202), this resistance exists in different forms such as path dependence (Section: 5.5.2.3, page: 225) and institutional inertia (Section: 2.3.4.2, page: 49). When the institutions resist any changes by following certain policies or performance it is known as institutional inertia (Angeles, Ngo and Greig, 2021). It is a social issue that is associated with individual and organisational behaviour and culture (Chapter Two, Section: 2.3.5.1.1; Section: 2.3.5.1.2, pages: 54-55). This social behaviour can affect the development of TVNs in Kuwait, Qatar, Jordan and Egypt. Institutional Inertia is the result of rigid policies and systems (Rosenschöld, Rozema and Frye-Levine, 2014). It delays or lacks flexibility in the decision-making process. This research revealed that there is a lack of participation and silence which is a defensive behaviour (Section: 5.2.1, page: 200), this is a result of insecurity and scrutiny from external individuals especially Western Academia (Chapter Three, Section: 3.5.2.2, page: 107). The literature review and research findings illustrated that the issue of silence was prominent in the organisation, which is the outcome of a lack of trust in management and the organisation as the finding showed there is a lack of administration support (Section: 4.2.3, page: 156). Therefore, the staff used silence as a defensive measurement. This fear and silence are also the result of bureaucratic issues in the organisations. Further, the participants illustrated some poor organisational decisions, especially during COVID-19 (Chapter Four, Section: 4.2.1, pages: 147-152; Section: 4.6.1.1, pages: 188-190). For example, staff deployments are based on organisation politics and preference. Bureaucratic issues such as nepotism are adversely affecting the nursing profession regarding recruiting and staff allocation to the departments,

whereas qualified people distributed among the departments is based on favouritism (Chapter Four, Section, 4.2.3, pages: 156). This can affect the allocation of qualified staff in the right place, based on their qualification and skills, performance and practice in wound management. The findings also show unequal distribution of staff and resources in the departments. This can create a kind of unpleasant working environment. In wound management, specialised wound nurses are expected to make decisions related to wounds, however, they lack the resources and power. Decision-making is one of the main roles and responsibilities of TVNs, however, with the existence of bureaucratic issues nurses are unable to make decisions. Therefore, it is focal to address bureaucratic issues in the workplace, to develop TVNs in Kuwait, Qatar, Jordan and Egypt. This includes governmental and organisational actions such as reforming administrative processes of recruiting and progression, enhancing administration flexibility and culture of openness and improving transparency in the organisation's decisions. This also could lead to changing community and healthcare provider beliefs about the nursing profession. Further, this will allow nurses to believe in themselves. By addressing these issues, nurses can be empowered to provide high-quality care and contribute to positive outcomes for wound management and skin care leading to improved organisation quality services and outcomes.

5.5.3.2 Decolonising Professional Knowledge

5.5.3.2.1. Colonising Knowledge Vs Decolonising Professional Knowledge

Colonising knowledge is a dimension of power that is used to develop the structure of the system, this shows the relation between different aspects such as superiority and inferiority between the dominant and the dominant ones (Bhambra, 2007; Pardo, 2020). Colonising knowledge also reflects the social and cultural hierarchies, as discussed in chapter two (Section: 2.3.5, page: 50). Whereas the people at the top of the organisational hierarchy are controlling the system and organisational structure. Therefore, the knowledge is controlled to be under their influence. It is also associated with professionalisation and the domination of some professions. In healthcare organisations, doctors are designing the policies in their favour, such as making decisions without engaging other health professionals and not allowing others to participate in decision-making (Chapter Four, Sections: 4.4, page: 170). Colonising knowledge was obvious from the findings, where the doctors do not allow nurses to engage in decision-making. It is a pattern of power that affects knowledge production (Pardo, 2020; Bhatti-Sinclair, 2022) and limits the scope of knowledge and practice of other professions to expand as a speciality. This research revealed that doctors perceive their knowledge as mentioned

earlier to maintain their power of knowledge. On the other hand, the research findings revealed that the decision-makers in Kuwait, Qatar, Egypt, and Jordan tend to develop restrictive policies and regulations to inhibit nurses from flourishing and progressing. These policies and regulations are controlled by doctors (Section: 5.5.2.1.1, page: 218) and tend to be used to isolate nurses professionally from decision-making, and then deskilling and decolonising nurses' knowledge. When the marginalised group (nurses) are disempowered can lead to decolonising knowledge (Büyüm et al., 2020). This research revealed that the issue of decolonising nursing professional knowledge is the outcome of conflict of interest, path dependency, cultural issues, gender inequalities, domination and discrimination between nurses and doctors, all these issues are interrelated and controlled by power. Decolonising professional knowledge limits the scope of nursing care and prevents the development of new approaches to improving skin care and wound management. This can take many forms, including academic research that is conducted without involving nurses. The findings illustrate that nurses never participated in any research in their organisation. Also, the findings from this research and data collection process clearly show the issues of decolonising knowledge. In which the gatekeepers during the data collection process were not allowing for participation (Chapter Three, Section: 3.5.2.2, page: 107; Chapter Four, Section: 4.2.1, page: 147). The finding revealed that there is a fear of external scrutiny, where the heads of departments (doctors) do not allow for participation to prevent nurses from expanding as a speciality and becoming knowledge producers.

As the nursing profession recently became more established, nurses' roles became more defined with specialised knowledge and skills, to enhance the social status of the profession. However, this research revealed that there is deskilling of nurses and there is a lack of engagement in the organisation's decisions, which leads to decolonising nurses' knowledge. Decolonising the professional knowledge of nurses and the exclusion can negatively impact the nursing profession and lead to a lack of trust in nursing as knowledge producers and then patients would not accept nurses' decisions related to wound management or other aspects of care. Further, increases the reliance on doctor knowledge only, as explored in the finding that patients trust doctors' decisions only (Chapter Four, Section: 4.3.2, page: 168). Besides, doctors are the ones controlling the knowledge in the health organisation due to their power and cultural influences (Sections: 5.5.2, page: 215, and 5.5.3, page: 228). In the context of the professions, decolonising nursing knowledge reflects the influence of power in generating and controlling knowledge, which is controlled by doctors, due to their level in the organisational

hierarchy an influence in developing the policy. Decolonising knowledge could also indicate the power imbalance in Kuwait, Qatar, Jordan, and Egypt as well as some aspects towards domination issues and conflict of interest, which all indicate that nurses are unable to exercise their knowledge and practise through making effective decisions related to wounds and skin integrity.

5.6. Kuwait, Qatar, Jordan and Egypt

5.6.1. Similarities and Differences

This research uses professionalisation to understand the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt, and further, to understand the absence of wound specialists in Kuwait, Qatar, Jordan, and Egypt. This chapter reveals the issues of gender concerning the first theme (power and authority) and the second theme (cultural influences). Also, lack of trust in nursing knowledge, because generally, nursing is a female-dominated profession, then in a culture that is ruled and controlled by males, hence, the power would be used to support male decisions only. Furthermore, using a professionalisation framework helps to explore the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. This research revealed that in Kuwait and Qatar, there is a significant nurse's shortage because the nationals are not interested in the nursing profession (Chapter Two, Section: 2.10.3, page: 72; Section: 2.10.4, page: 74). Therefore, both countries are relying on foreign nurses such as from Jordan and Egypt. In contrast, in Jordan and Egypt, the issue of nurses shortage exists because nurses are leaving to work in Gulf countries such as Kuwait and Qatar, further population size in Egypt and Jordan is higher than in Kuwait and Qatar, this leads to an increase in the demands for nurses (Chapter One, Figure: 1.6, page: 14; Chapter Two, Section: 2.10.1; Section: 2.10.2, pages: 70 and 71). Professionalisation focuses on training, to improve staff skills and the profession, however, this research revealed that after spending a significant amount on training, nurses are leaving Kuwait and Qatar for better working opportunities abroad such as in the UK, Canada, New Zealand, and Australia, see Figure 5.10.

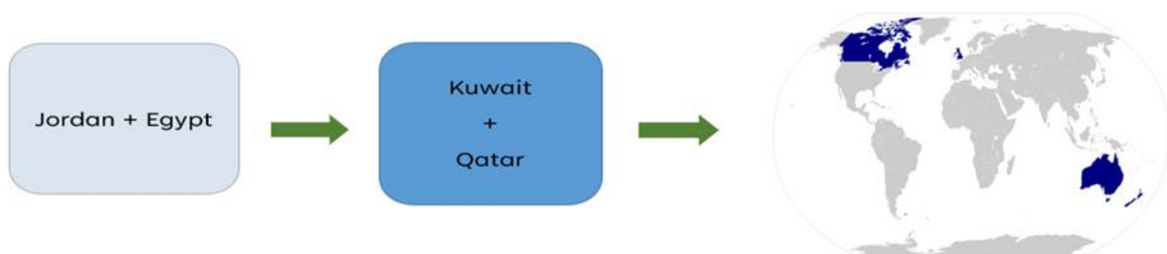


Figure 5.10: Nurses Immigration

In terms of policies, it focuses on training as part of developing the staff, despite that, the findings from this research revealed that Kuwait, Qatar, Jordan, and Egypt focus on training, whereas nurses leave the country for better working opportunities. The policies need to focus on different elements apart from staff training. Ministries must focus on staff retention and improve the working conditions, then can improve the training to develop TVNs. In regard to the investment and the infrastructure, this research revealed that Kuwait and Qatar are substantially investing in developing new hospitals and providing advanced technologies to improve health facilities. Whereas in Jordan and Egypt, there are limited financial resources.

5.6.2. Insider and Outsider

This research explores several issues related to the profession and the area of wound management in Kuwait, Qatar, Jordan and Egypt, the findings illustrated in Figure 5.11. The exploration of these issues developed based on trust between the participants and the researcher as a Kuwaiti female working in the health sector for 18 years. Being an 'insider' and native with certain years of experience contributes to accessing the participants not only from Kuwait but also with the assistance of the policymakers in Kuwait, further participants from Qatar, Jordan and Egypt were included (decision makers and gatekeepers). This is the advantage of being an insider. However, some limitations exist due to the researcher's gender and the professional role as a nursing leader and quality in-charge and surveyor (Chapter Three, Section: 3.11.2.2, page: 141). At some points during the data collection and while conducting the interviews, the researcher was considered an 'outsider', and the access to the participants was limited, further some of the participants were inexpressive about their thoughts and stayed silent. Also, the association of the researcher with Western supervisors and the University (Chapter Three, Section: 3.5.2.2, page: 107) could be a reason for considering the researcher as an outsider.

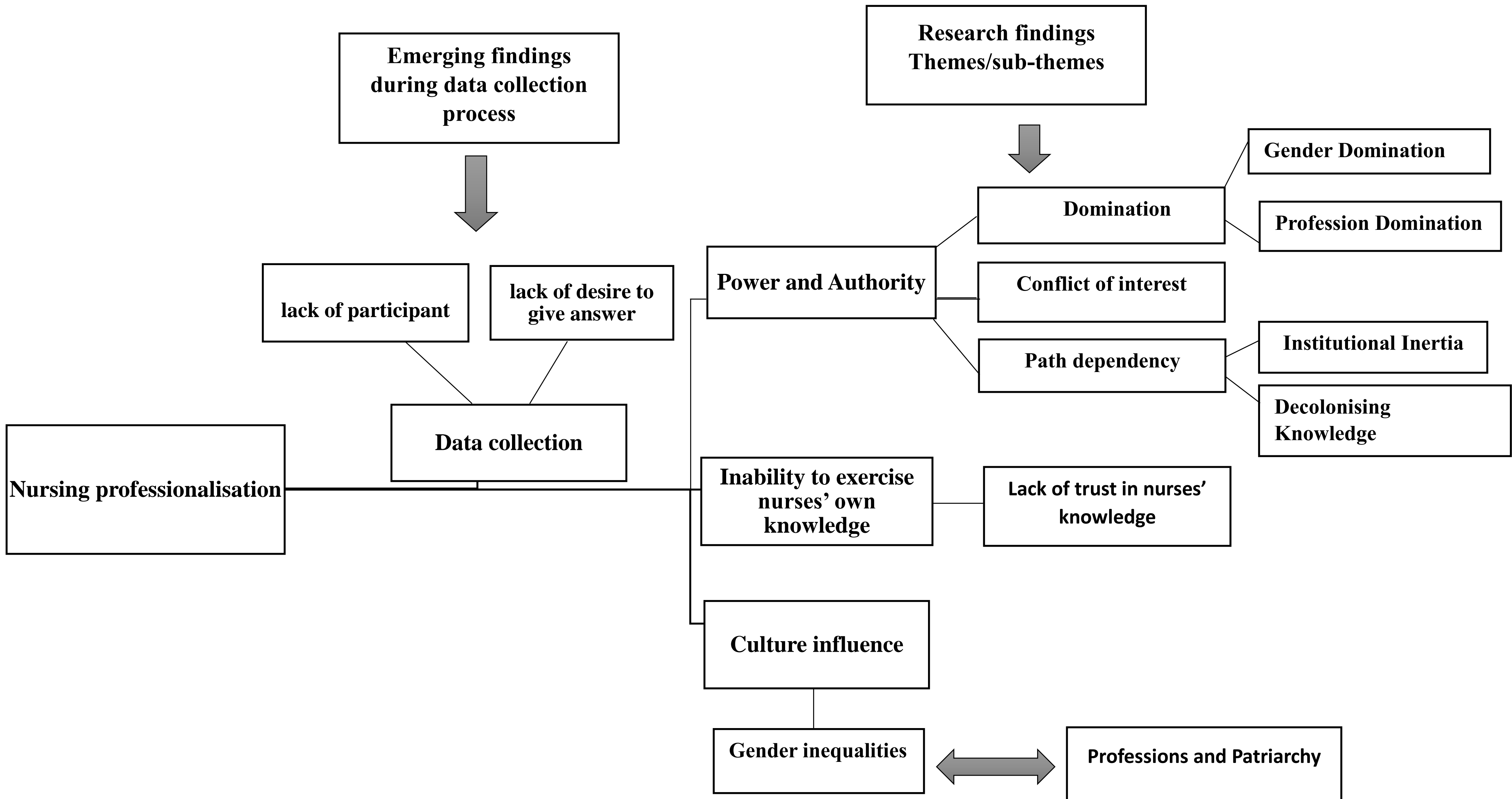


Figure 5.11: Research Findings

5.7. Feasibility and Limitations of the Professionalisation

In order to develop specialist nurses in tissue viability and wound management, this research used a professionalisation framework. This research used professionalisation to enhance the understanding of the development of nursing as a career (Wall and Hallett, 2018). It also increases the awareness of the nursing profession and expands nurses' scope of knowledge and practice. From a social science perspective, applying this research helped to understand individuals' practices regarding wound management and dealing with chronic wounds, and how they interact with each other to make decisions. Further, the process of nursing professionalisation itself allows the researcher to explore hidden aspects that are integrated into the sociology of the nursing profession, that have never been explored in-depth before in Kuwait, Qatar, Jordan, and Egypt.

This research underlines some contextual factors such as organisational, social and cultural aspects, that impede the development of TVNs. These factors are influenced by power dynamics, organisational structure, behaviour, culture, society perceptions, social norms, the role of gender and individuals' beliefs and perceptions about their role, which translated as behaviour and actions in practising their duties related to wound management and skin integrity. Understanding and dealing with these issues is considered a key aspect of developing TVNs in Kuwait, Qatar, Jordan, and Egypt. For example, in male-dominated societies where the female role is unequal, the decision-making role is centralised among men, which makes females unable to raise their specific issues, even if they raise any issues the decision-maker mostly will not take any actions due to gender inequalities and patriarchal issues. This research aims to empower nurses in health organisations and facilitate their role in decision-making related to wound management. However, facilitating this role can possibly create a dispute and conflict with doctors due to domination issues and power imbalance.

On the other hand, professionalisation emphasises on educational credentials, such as degrees and certifications, further developing nurses' knowledge through attending special courses. This means it focuses on qualifications and credentials while neglecting other aspects such as staff's emotions (exhaustion and burnout) and ability to professionally develop. Professionalisation focuses on academic qualifications rather than individual experience and skills, where more experienced or educated nurses can have more power than other nurses with nursing certificates or diplomas. This can create a disengagement of nurses and discouragement of collaboration among nurses, thus leading to resistance due to institutional inertia and path dependency. From a social lens, social favouritism and nepotism can also lead to an unhealthy

working environment such as some employees with similar credentials can attain promotions while others cannot. For example, if most nurses are with high qualifications, it can lead to a rigid hierarchy within the nursing profession. The research findings revealed that professionalisation can also lead to conflict due to staff competition to secure power (the power of leadership and promotions based on qualification). However, those nurses in leadership positions have the power, but they lack the authority to make decisions, which is the main key aspect of professionalisation. Additionally, having a higher degree is not a criterion, that nurses can perform better in their jobs. In some cases, nurses with diplomas have better clinical experience and skills. Additionally, this research illustrated that developing TVNs requires expanding and changing the organisation set-up to fit the new speciality. Besides, to obtain training nurses require the infrastructure such as a conference room and spare time to attend those training. Despite that, the finding revealed that nurses in Kuwait, Qatar, Jordan, and Egypt; cannot use their knowledge in decision-making due to several barriers and challenges that impede their ability to develop as a speciality in tissue viability. Consequently, the finding revealed that nurses' abilities do not use optimally and their actual role in healthcare is underutilised regardless of their qualifications. This research also showed that there is a lack of trust in nurses as knowledge producers, underpinning the importance of wound management and TVNs roles. Furthermore, this research revealed that doctors are considered superior to nurses due to the organisational structure where the nurse's position in the organisation's hierarchical level is always lower than doctors'. This impacted the development of nursing knowledge and practice which doctors used to decolonise nursing knowledge to avoid nursing profession flourishment.

5.8. Methodological Contribution

The use of a generic qualitative method added value to this research, by exploring and understanding the reality of health professionals' behaviours and practices toward professionalisation of nurses. Therefore, this qualitative data provided a vigorous understanding of the issues behind the absence of specialisation in nursing in Kuwait, Qatar, Jordan, and Egypt. However, there were some kind of limitations while applying generic qualitative methods because it is not well-defined and lacks literature(Chapter Three, Section: 3.4.2 , page:100).

The pandemic of COVID-19 worldwide has a significant methodological contribution to this research, by conducting virtual interviews through Microsoft Teams due to the health restrictions. The use of technology made conducting this research possible during the pandemic. Further, the utilisation of online tools such as email (sharing consent and participants' information sheets) and Microsoft Teams (audio and video recording) enables the researcher to conduct qualitative research. Apart from this, it facilitates the researcher to get insight into the research by taking account of behavioural aspects during interviews. The ability to accommodate the evolving methodology based on prevailing circumstances and requirements is essential for researchers to conduct effective research (Chapter One, Section: 1.1, page: 3).

On the other hand, the application of semi-structured in-depth interviews and the evolving phases of this research showed that the method can be applied without geographical limitations. It also illustrated that one method can serve the research purpose even with the inclusion of multiple countries. Therefore, this research showed how the researcher deals with and adapts to different situations such as a lack of participants and developing further sample sizes by using snowball sampling, to give access to participants without geographical limitations. Sharing this experience in the data collection process can benefit other researchers to deal with similar situations.

5.9. Research Contribution to Knowledge

This research adds new knowledge related to the nursing profession, professionalisation, skin integrity and wound management which has not been explored before in-depth in a country such as Kuwait, Qatar, Jordan, and Egypt. This research showed that knowledge is a significant element in developing the profession, hence, when it comes to the profession, individuals are required to have a certain level of education and criteria to exercise their knowledge by making decisions. However, individuals need to have the power and authority to determine who can exercise this knowledge. For example, professionalisation allows individuals to diagnose, but when it comes to nurses, they cannot make clinical judgments or decisions (diagnose), the full authority for doctors. This research revealed that nurses have neither power nor authority in Kuwait, Qatar, Jordan, and Egypt. Therefore, this research explores several aspects that impede nurses to diagnose, such as the history and development of the profession. In Kuwait, Qatar, Jordan, and Egypt nursing began officially

between 1950 to 1960, yet there is no societal and cultural acceptance of the profession. Also, medicine is considered as a prestigious profession, whereas nursing is not (Chapter Two, Section: 2.3.3, page: 43). Leading to a lack of trust in the profession along with a lack of power to generate knowledge. Nurses could have the ability and capacity to generate knowledge, but for that, they need more than knowledge and experience. It is about the power dynamic and authority that allows nurses to diagnose and make decisions, which is associated with their level in the organisation hierarchy.

The research finding also illustrated that power significantly impacts the nursing profession, and nurses' level in the organisation hierarchy and shaping their role and responsibilities within the healthcare system. It also influences the way that nurses are providing wound care which prevents nurses from practising their knowledge effectively related to patient care and wound management. The influence of power is associated with organisational, cultural, and social aspects. In any organisation, power is integrated into the structure, and system and makes those organisations powerful. It shapes the way that individuals think, behave, and exercise this power. For example, throughout history, the system has been developed in a way that nurses are subordinates to doctors, where nurses have to follow doctors' instructions only without being involved in the decision-making. This research illustrated that nurses in Kuwait, Qatar, Jordan, and Egypt are following the same path. This is an invisible power that develops individuals' beliefs and perceptions about nurses' roles, which is an established operational procedure that is embedded within the system. Therefore, the findings from this research can be used as a reference for future research in similar areas from those countries or it can expand to other countries.

5.10. Research Contribution to Science and Practice

The role of nurses related to tissue viability and wound management is limited in Kuwait, Qatar, Jordan, and Egypt. Therefore, conducting interviews with decision-makers increases the awareness and understanding of the need for tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt. The use of a sociological framework helps to understand the gatekeeper reactions toward developing new nurses' specialities (silence and avoiding participation in the research). These issues underlined deeper issues related to organisational culture and power dynamics in the organisation. That also underpins individual behaviours and practices in dealing with organisation regulations and rules, which are formed as self-

regulations and norms of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. Further, this research highlighted the operational flows of the nursing profession and the legitimacy of nurses' power in making clinical or administrative decisions in the respective countries. There can potentially be initiatives and measures to initiate tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt. For example, it boosts nurses' engagement in academic research and provides professional development opportunities to elevate nurses' status and change their practice in dealing with wounds and chronic skin conditions.

5.11. Summary

The findings revealed that the understanding of professional knowledge about skin integrity and wound management along with potential grounds for having separate sections of skin integrity and wound management within the nursing profession. The undermining of the nursing profession along with organisational, cultural, social, and behavioural aspects related to nursing is the main limitation towards the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt. Moreover, the silence of nurses regarding their rights and professional standing, cultural values of male domination, and lack of trust in the nursing profession are other attributes that make the nurses unable to work to the best of their abilities. Also, the fear of nurses' development was quite prominent in the findings, which is associated with power dynamic and organisational aspects related to power and authority, gender and professional dominance, institutional inertia, and the decolonising of professional knowledge. Each aspect of nursing care influences decision-making, these decisions related to the care require training and updates of the knowledge, it is an ongoing process that might lead to staff exhaustion and then resistance. Therefore, with the existence of these challenges and their grave nature, it would be challenging to develop the nursing profession and implement professionalisation. The next chapter provides the conclusion and recommendation.

CHAPTER SIX
CONCLUSION AND RECOMMENDATIONS

6.0. Research Conclusion

Evolving specialist nurses in tissue viability in (Kuwait, Qatar, Jordan, and Egypt) is an opportunity for the nurses. Professionalisation facilitates understanding nursing as a career, it also provides opportunities for nurses to expand into new areas. However, this research revealed that the professionalisation of nursing is challenging and controlled by social, political, organisational, and cultural power, which is linked to the history of the development of the nursing profession. Recently, the nursing profession has become more established, and their role has become more defined with specialised knowledge and skills, due to their involvement in academia and research. However, nurses are not well accepted as knowledge producers, because their level of study and grade are considered to be less than doctors. Further, doctors occupy the top positions in the organisation's hierarchical structure. This hierarchical structure leads to the power imbalance between doctors and nurses, which also leads to domination and supremacy, therefore, the policies are developed in the favour of doctors. The consequences of this hierarchical structure negatively impact nurses' role in the health organisation, by following certain behaviours and actions while dealing with doctors. Within these behaviours, there was silence and fear of the policies which formed and developed based on decision-makers and doctors' interests. These policies were used to control nurses' practice and limit their scope of knowledge. This research revealed that in Kuwait, Qatar, Jordan and Egypt, the organisation's hierarchical structure, power dynamics and the distribution of power in the health system are shaped according to the profession or gender, this reflects a male-dominant society. This structure and power are also associated with the patriarchal culture and tradition of the societies in Kuwait, Qatar, Jordan, and Egypt, where females faced discrimination and used to be undervalued and treated lower than men. Furthermore, decisions are made by only men as they are leaders of the home. The nursing profession is considered socially lower than doctors due to the social and cultural hierarchy of the system. Therefore, this research revealed that the culture is forming and shaping the power in Kuwait, Qatar, Jordan, and Egypt. Further, this power is structuring and controlling the system, thus making nurses unable to make decisions related to wound management and skin integrity. Therefore, this qualitative research has achieved its aim by answering research questions and achieving its objectives as shown in Figure 6.1.

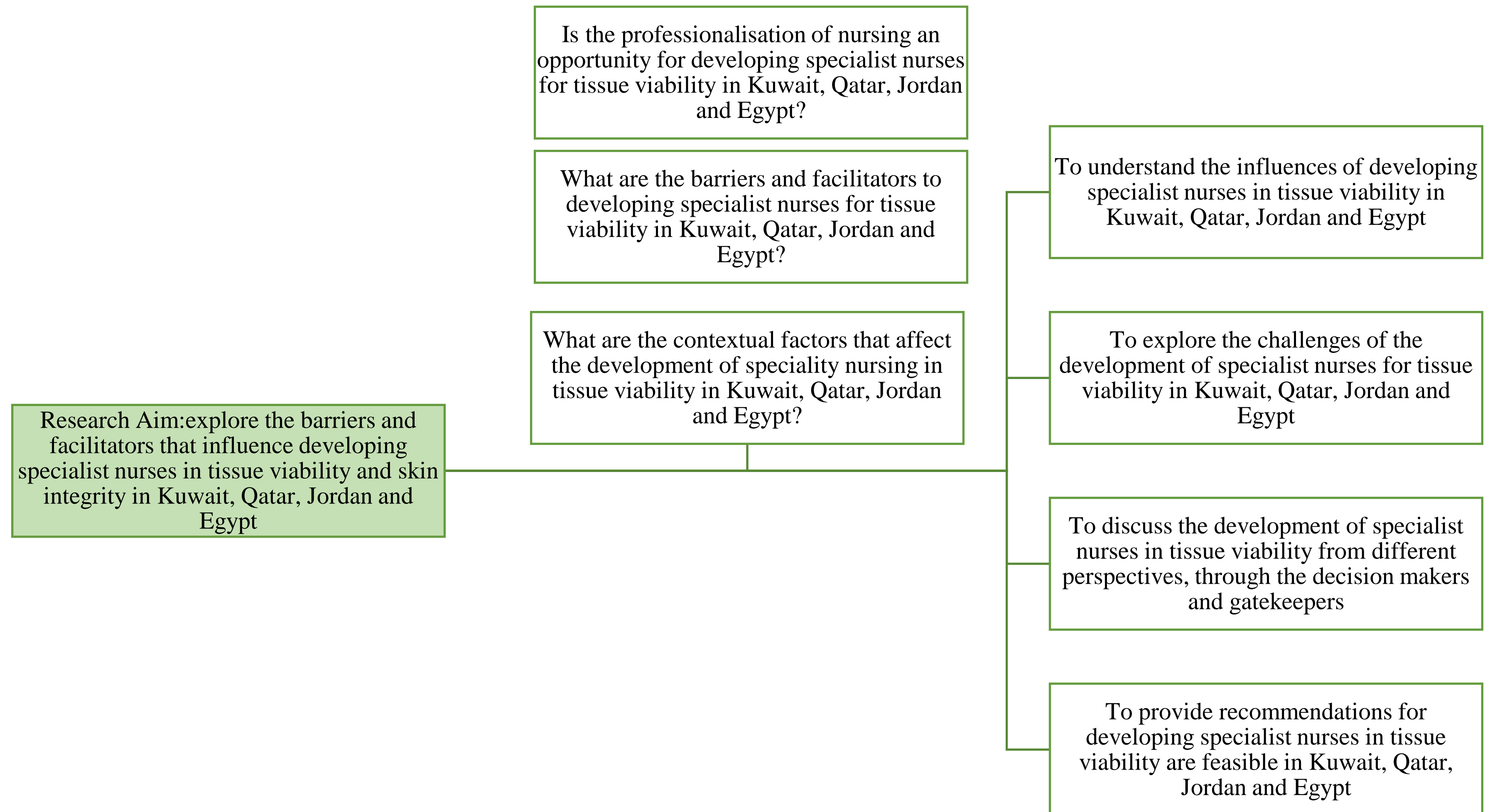


Figure 6.1: Research Aim, Objectives and Questions

This research concludes by answering its questions and achieving its objectives as follows:

The barriers and facilitators to developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan and Egypt

Individual behaviours and practices related to wound management are associated with power; this power is exercised through government policies and the hierarchical structure of healthcare organisations. The power that controls the system and nurses is generated from the culture and translated into protocols and policies. The policy is essential to support nurses' development as a speciality, further, enabling them in decision-making. However, this research revealed it did not support nursing development and it leads to two potential outcomes. The existence of the policy can lead the administration to use it as a tool for controlling nurses. Furthermore, the policy itself can be violated by individuals and lead to non-compliance in Kuwait, Qatar, Jordan, and Egypt (Chapter Five, Section: 5.5.2.1.1, page: 218). Therefore, this research explored that policies are used as professional boundaries that control nurses' roles and limit their scope of knowledge hence, it is a barrier to developing TVNs (Chapter Five, Section: 5.5.2.1.1, pages: 218-219). This research showed that nurses are afraid of stepping out of their professional role and they fear the system which is controlled by the decision-makers and organisation management who are usually doctors by profession. This fear of the system is generated by the culture (as gender roles are defined), power dynamics and organisational structure. This in return leads individuals to be silent and refuse to participate in this research and resist change in their practice for both doctors and nurses, due to the institutional inertia, power dynamic and domination issues.

Developing TVNs in Kuwait, Qatar, Jordan, and Egypt require the availability of educational institutions, certification and other resources which are controlled by the decision-makers. Hence, their power is used to control the resources and limit nursing professional development opportunities, due to domination issues and supremacy, gender inequalities and patriarchal culture, thus maintaining the status quo. This research revealed that doctors used their power to decolonise nurses' professional knowledge and deskilling of the nursing profession and further limit the profession to expand in different specialities. Despite that, this research showed that in Kuwait, Qatar, Jordan and Egypt, the awareness increased toward improving the quality of care (Chapter One, Section: 1.8, pages: 30-31). This can support the development of TVNs units, to improve the quality of care. Also, the pandemic of COVID-19

enhances the awareness of the nursing profession and nursing role. Hence, developing specialist nurses in tissue viability is a chance for newly graduated nurses to explore new areas in the nursing profession.

The influences of developing specialist nurses in tissue viability in Kuwait, Qatar, Jordan and Egypt

Applying the professionalisation framework in this research explores hidden aspects related to individuals' behaviour and attitudes in organisations in Kuwait, Qatar, Jordan and Egypt. It also showed there is a lack of awareness about TVNs and a lack of understanding of the importance of their role (Chapter: Five, Section: 5.5.1, page: 211). However, performing this research in Kuwait, Qatar, Jordan, and Egypt enhances the understanding of TVNs role and their scope of knowledge, it also increases individuals' awareness of nursing specialities. The professionalisation of nurses helped to understand the social aspect of the profession including the interaction between nurses and doctors and silence issues. Developing TVNs explored actual nursing roles and practices related to wound management and skin integrity and how path dependence issues are deep-rooted in health organisations, which reflects the rigidity of organisational culture in the respective countries. Silence aspect also helped to explore critical issues related to the nursing profession and power dynamics in the health organisations in Kuwait, Qatar, Jordan, and Egypt. Therefore, this research illustrated how professions vary in terms of power, authority, and decision-making. Doctors are exploiting the authority for their benefit, in developing the organisational structure and controlling nurses' role. Some issues need to be dealt with first to develop a new speciality in tissue viability, such as power dynamics, dominations, power imbalance, gender inequalities, organisational culture, decolonising professional knowledge and institutional inertia. This significantly led nurses to be silent and then affected nurses' role in decision-making. Therefore, developing TVNs would require collaborations from the government and healthcare providers to increase the awareness of TVN's role first, then enhance nurses' engagement in the research areas and conferences to enhance their role in the organisations and develop new knowledge and skills in dealing with wounds.

The contextual factors that affect the development of nursing speciality in tissue viability in Kuwait, Qatar, Jordan and Egypt

The finding of this research reveals that the wounds speciality does not exist in Kuwait, Jordan and Egypt. Nevertheless, in Jordan and Egypt, TVNs are available in the private sector only. In Qatar, TVNs exist in the private sector and one main governmental organisation (Chapter Five, Section: 5.5.1, page: 211). The lack of this speciality is because of the challenge of managing priorities, for example, the governments or decision-makers aiming to achieve their targets without considering the fact of staff shortage and the impact of the COVID era and increased workload. Sometimes, governments or administrations make decisions based on their interest or priorities which could be built upon quantitative aspects rather than qualitative aspects. In line with the strategic plan of Kuwait and Qatar, the governments are spending a significant amount on training to achieve the target numbers, however, the implementation and execution are ineffective. For example, the government provides training to improve wound management and skin integrity to promote health services as part of the government's strategic plan. Despite that, there is a lack of evaluation and follow-up of this training. This research revealed that nurses are overwhelmed with the training programme. In Kuwait, Qatar, Jordan, and Egypt, the administrations focus on numbers instead of measurable outcomes. Indeed, always nurses have been the last priority due to organisational, cultural, and social aspects. The low social state of the nursing profession is the result of different perspectives and power imbalance. For instance, developing TVNs requires nurses' engagement in the treatment plan, which encompasses changing the organisation structure. Hence, changing nurses' role in the organisation and giving them authority for making decisions. However, this research revealed that nurses do not have the authority to make decisions. This research also found that developing TVNs is unwelcome due to fear of altering the distribution of power in the organisation. When the power is controlled by doctors then they would resist this change to avoid losing their power.

The challenges of the development of specialist nurses for tissue viability in Kuwait, Qatar, Jordan, and Egypt

Developing TVNs is associated with organisational, cultural, contextual and social factors. Therefore, applying a qualitative method provides an in-depth understanding of the underlying phenomena. Through conducting semi-structured in-depth interviews to understand how individuals are thinking and behaving in the system, allows to explore nurses' roles related to wound management. The research findings are summarised in three main themes (power and authority, inability to exercise nurses' knowledge and cultural influences), including individual behaviours and practices related to wound management and developing new areas of nursing specialisation. The absence of nursing specialisation in Kuwait, Qatar, Jordan, and Egypt is because of the role of females in developing the nursing profession. In conservative societies such as Kuwait, Qatar, Jordan, and Egypt, female roles are limited, and voices are not acknowledged. Therefore, there is limited professional development opportunities for females. This research revealed that educational institutions, certification, and other resources are controlled by the decision-makers and powerful personnel at the top level in the health organisation hierarchy, which is usually male. The nursing profession has been historically undervalued, due to the female dominant role in organising and managing the profession, hence, this structure of the profession is embedded within the culture in Kuwait, Qatar, Jordan, and Egypt. On the other hand, as decision-makers are male dominant, hence, the policies would be developed in their favour as males and doctors (gender domination, patriarchal culture, professional domination). Then, developing policies to empower nurses' role in the organisation and change the current system would be challenging. The culture creates a barrier for nurses and other healthcare providers to accept changing nurses' roles and making decisions about wound management. Apart from wound management, nurses' roles and responsibilities related to patient care are limited, due to the invisible power. This power is integrated into the health organisation and society and then controls individuals' thinking, behaviours and actions. It is translated into a form of policies, guidelines, norms, and traditions that control nurses' practice and behaviour toward wound management. This research revealed that the power is used even to control and decolonise nurses' professional knowledge, hence, impeding nurses from being knowledge producers. Sometimes, governments or organisations make decisions based on interest or agenda which could interfere with nurses' priorities to develop and expand as a speciality. As a result, these factors create an obstacle or resistance for nurses to develop as TVNs.

The development of specialist nurses in tissue viability from different perspectives, through the decision-makers and gatekeepers

The perspective of the decision makers and gatekeepers is explored in chapter four (Section: 4.5.2, pages: 182-185). Overall, this research explored that developing TVNs is not welcomed, there is fear of developing new areas where nurses need to adapt to the new changes in their practice and role. This reluctance to accept this speciality is related to the issues of resistance (path dependency and institutional inertia). This research showed that individuals in the organisation are not willing to change and they prefer to continue a similar practice and path even if it is old and ineffective. The decision-makers require understanding these barriers to health professionals' behaviour and beliefs, about the nursing profession. Provide opportunities by engaging nurses academically and professionally, through conferences and meetings and ensure nurses are actively involved in decision-making. The professionalisation of nursing is an ongoing process that can have a significant impact on nurses' performance and practice through specialised knowledge and skills. Hence, to improve their practice and performance nurses require consistency in training and updating their knowledge as part of the professional development. This is considered as a professional boundary that is challenging for nurses to cope with in the current working situation due to staff shortages and increased workload. Moreover, training and improving nurses' knowledge is an integral aspect of nursing professionalisation, hence, with the absence of resources such as infrastructure, technology and other resources, tissue viability nurses' speciality cannot progress.

Is the professionalisation of nursing an opportunity for developing specialist nurses for tissue viability in Kuwait, Qatar, Jordan and Egypt?

This research revealed that the professionalisation of nurses supports changes in nurses' roles and practices. Further, developing nurse's knowledge is an essential part of the professionalisation process. It requires ongoing training, which seems to be difficult to achieve due to the impact of COVID-19 in Kuwait, Qatar, Jordan, and Egypt, such as staff shortage and staff exhaustion. The professionalisation of nurses emphasises on enhancing the professional development of both genders. However, this research shows that the female role in the organisation is not equal to male, even in a similar profession. The issues that females face in Kuwait, Qatar, Jordan, and Egypt are similar regardless of the geographical location of the country. Conducting this research in conservative countries, where the cultural norms,

traditions and society are significantly influencing the nursing profession. This culture leads to unequal distribution of opportunity, then creates the psychology to select specific professions based on gender. For example, the social aspects related to the nursing profession such as acceptance of nurses' role or non-acceptance contribute to shaping individuals' beliefs, thoughts, and behaviours to the nursing profession. Furthermore, professionalisation focuses on educational credentials and qualifications rather than practical skills. This could create a hurdle for some nurses who cannot proceed to higher education in nursing, especially in Kuwait, where the highest academic qualification that nurses can achieve in the country is undergraduate. In addition, professionalisation requires knowledge, skills and changing individual beliefs, behaviour, and practice, then enable nurses to have the power and authority to exercise the power of the profession and then make effective decisions related to wound management. However, the findings of this research revealed there is limited power for nurses in Kuwait, Qatar, Jordan, and Egypt. In some cases, even nurses have the power but lack the authority. Hence, this research explored underlying issues that impeded nursing professionalisation and associated with various aspects that are translated to three main themes as follows: power and authority, the inability of nurses to exercise their knowledge and cultural influences. Further, subthemes as shown in Figure 6.2 have been explored in this research. These themes developed based on organisational, cultural, social, and historical factors that influence the development of nursing professionalisation.

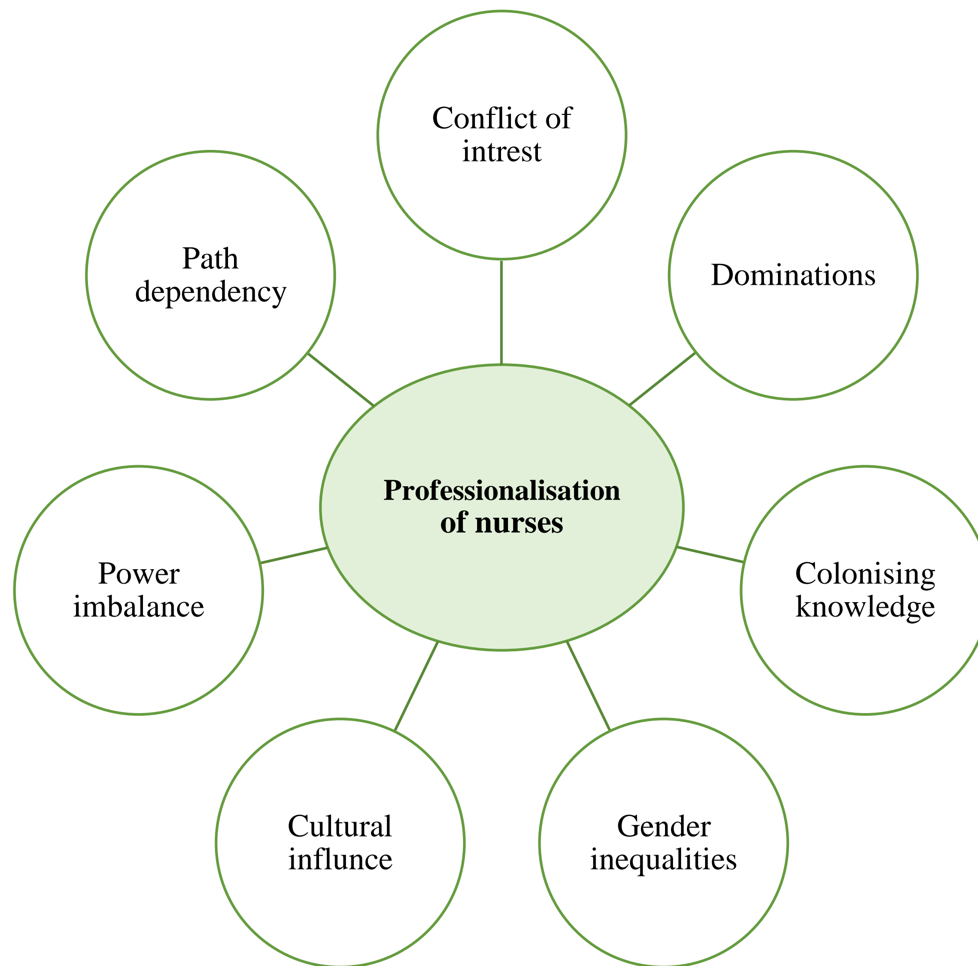


Figure 6.2: Issues Associated with Nursing Professionalisation

6.1. Strengths and Limitations of the Study

The research strengths that have contributed to the knowledge along with research limitations are as follows:

6.1.1. Strength of the Study

The lack of previous empirical research related to wound and skin integrity and professionalisation in Kuwait and their contribution to existing empirical research on Qatar, Jordan and Egypt.

This research is the first research to use a professionalisation framework to enhance nurses' role in wound management in Kuwait, Qatar, Jordan, and Egypt. Further, nurses' role related to skin integrity and wound management is considered for the first time in Kuwait in this research. The gap in the knowledge related to nurses' role in wound management has been

explored in this research. Several issues emerged related to the power dynamics, organisational issues (organisational culture or behaviour), cultural issues such as (gender inequalities, beliefs and norms) and behavioural aspects in dealing with other health professionals such as silence, superiority or domination and fear. These issues significantly influenced the development of the nursing profession in Kuwait, Qatar, Jordan, and Egypt.

Considering the input of the decision-makers in the Ministries of Health and the inclusion of their voices.

Nursing is a noble career that has evolved academically, professionally, and socially. However, nurses have a limited role, due to the power influences and the distribution of power in health organisations in Kuwait, Qatar, Jordan, and Egypt. Also, different organisational and structural issues were revealed in this research. Therefore, the inclusion of the policymakers/decision-makers in the Ministry of Health adds value to this research and their influences in changing the current system. This can facilitate the establishment of specialist nurses in tissue viability, by changing the system, enhancing nurses' level in the organisational hierarchy according to their role and qualification and changing the organisational structure to accommodate with the changing of their role in the organisation. Empowering nurses and enabling them in decision-making and encouraging nurses' professional development opportunities.

The inclusion of more than one target country has been a source to consider multiple perspectives and operational settings.

This research revealed that nurses are facing similar issues and challenges in their respective countries, regardless of the facilities or resources of the country. Sometimes, the resources and the infrastructure are available for nurses' development. However, nurses' lack of commitment and engagement curtail nursing development. Applying a professionalisation framework enables the exploration of the issue related to the development of nursing as a career in Kuwait, Qatar, Jordan, and Egypt. In this research, the opinion of the national nurses is required whereas the nationals are not in the profession substantially in Kuwait and Qatar (Chapter Five, Section: 5.6.1, page: 233). In both countries, the nursing profession is dominated by expatriates, such as individuals from India, Jordan, and Egypt. Hence, during the interview, the opinion of those foreign nationals has been included which serves as a research strength.

The professional background of the researcher helps to Mobilise respondents because of their professional status.

In the health profession, there is always defensive behaviour towards the professional status and role. That relates to the profession in which individuals in the profession need to have a certain level of knowledge. It was important to understand the professional knowledge of individuals associated with the nursing profession. Therefore, the background of the researcher facilitates collecting data from the decision-makers and gatekeepers. Being an insider helps to understand the organisation's regulations and formalities in Kuwait, Qatar, Jordan and Egypt, and also develops trust between the researcher and the respondents. Furthermore, the role of a female researcher facilitates female respondents to share their thoughts and concerns and speak freely.

6.1.2. Limitations of the Study

Pandemic of COVID-19

Based on the Pandemic of COVID-19 and the uncertainty of the situation, the research needed to be restructured, further, the research scope changed. Then a lack of participants from Kuwait led to expanding the research to four countries (Kuwait, Qatar, Jordan, and Egypt) to strengthen the data. This change has led to further delay as the literature review has to be modified. Hence, the research became more extensive and more time-consuming based on data collection and analysis from multiple countries.

Gatekeeping

The gatekeepers were assumed to facilitate the research process, however, one of the main limitations of this research was accessing the gatekeeping. In the initial stage of data collection, the gatekeepers were preventing the researcher from accessing participants, due to the gender bias and the professional role and background of the researcher as a nurse and quality surveyor. Being a female researcher in a conservative society attempts to create hurdles in accessing those gatekeepers, which then delays the data collection process.

Recommendations for developing specialist nurses in tissue viability are feasible in Kuwait, Qatar, Jordan, and Egypt.

The recommendations in this research are set for different-level starting from individuals and then organisations and communities. Hence, for the successful development of specialist nurses in tissue viability, first, there is a need to enhance the awareness of tissue viability nurses and their importance in managing and making decisions related to chronic and complicated wounds, that can be achieved by the decision-makers with the support of the media. Besides, the engagement of different stakeholders such as people at the top hierarchical level in the Ministry of Health would help to set new organisational structures to support changing nurses' roles related to wound management, according to international standards. This will also allow them to discuss and address the previous underlying issues for example, provide financial and human resources to empower the nursing profession and develop specialist nurses in tissue viability. Further, empowers female nurses by increasing their engagement and presence in academic research to influence their thought process for changing their practice and eliminate the chances of resistance, besides facilitating the female role in society while considering cultural restrictions and boundaries. Develop an exclusive department to discuss female issues and affairs that include developing policies without the influence of males.

This research also shows that nurses were tired and exhausted from intensive training, therefore, it is important to consider staff ability and interest in developing wound speciality. At the organisational level, it is important to deal with the nursing shortage and recruit sufficient staff while considering diversity to support nursing professionalisation. Ensure transparency in organisational annual decisions and allocate nurses based on knowledge and experience. Further, make rotations for leaders to eliminate bureaucratic issues such as nepotism. This research considers the thoughts of the gatekeeper and decision-maker however, wound management is a public health and community-based issue; therefore, it is important to consider the community and individuals' beliefs, behaviours, and actions toward the nursing profession and how this can influence the development of TVNs in Kuwait, Qatar, Jordan and Egypt. Moreover, expand the research to other parts of the world such as Western countries (developed countries) to learn from their experience in developing TVNs, and compare and contrast the research findings with those countries and look for the issues if it Is similar or different. Additionally, more questions could be considered in the future related to this research such as: What are the required hierarchical changes in the nursing profession?

6.2. Next Step

This qualitative approach illustrates that TVNs exist in the private sector in Egypt and Jordan, therefore, it is vital to expand the research between the government and private sector. In the case of Kuwait, establishing a TVNs unit in one government hospital as a Pilot study would help to assess and evaluate this speciality. It would also help nurses to adapt to the new changes. This research explores several issues associated with nursing professionalisation, these issues are associated with political, organisational, social, and cultural aspects, that include gender inequalities, patriarchal culture, bureaucratic issues, power imbalance, and dominance issues. This research also highlighted the issues of global nurses' migration along with the global supply chain, and how it is affecting the health system due to severe nurse shortages. This also impacted the development of TVNs and the state of the nursing profession worldwide. Hence, these issues will be considered intensively in future research and can be part of a chapter.

Additionally, the research findings were presented at 34th The European Wound Management Association conference in London on 2nd May 2024. Also, disseminate the research through international and global conferences such as presenting at the International Sociology Association meeting in Rome/Italy on 24-26 June 2024, and the 8th Global Symposium on Health Systems Research - Building Just & Sustainable Health System: Centering People and Protecting the Planet in Nagasaki, Japan on 18-22 November 2024. Publish a research paper in an international health journal. Participate in International Conference on Transcultural Nursing and Strategies in Kuwait on 7th August 2024, International Conference on Nursing Management and Nursing Leadership in Alwakrah/Qatar on 15th November 2024. In addition, Arab Health Symposium (World Trade Center) in 27-30 January 2025 in Dubai/United Arab of Emirates.

DATA AVAILABILITY STATEMENT

"Data supporting this study are available from NTU Data Archive at: (DOI. This is currently being registered by Library Research Team). Access to the data is limited to researchers affiliated with research organisations due to legal and ethical considerations. Requests to access the data should be directed to LIBResearchTeam@ntu.ac.uk."

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Appendix

Appendix 3.1 Semi-Structured In-depth Interview Question

Semi-structured interview (Decision-Makers)

1. Can you tell us about your role and duty in the organisation?
2. How do you view your organisation's policies and regulations related to the provided care, how do you think it can enhance skin integrity and wound management?
3. Do you think improving skin integrity and wound management should be a part of the mission and vision of the organisation? How do you think this can improve the skin care and wound management?
4. Do you think including skin care and wound management training in strategic planning is beneficial for the organisation's outcome? How can this benefit the organisation?
5. Is it beneficial to have a specialised nurse in skin and wound management in your organisation? Why?
6. Is providing specialised nurses in the skin and wound can facilitate nurses' role in implementing efficient patient care and decrease workload for general nurses and doctors? Can you explain that?
7. Do you think the nurses have sufficient knowledge that allows them to manage and decide better than another health profession related to wound management? Explain, how?
8. What are the organisational, cultural and contextual factors that influence the implementation of new nursing speciality? How do you think these factors could affect the new speciality and how you will deal with such factors?
9. Is it significant to have a new nursing speciality in your organisation, do you think could be useful as an enabler for skin integrity? How do you think this could improve skin integrity and wound care?
10. What are the main opportunities and challenges that you encounter related to developing specialist nurses for wound management and skin integrity at your organisation?
11. Is developing a new speciality related to wound management and skin integrity bringing a negative or positive impact on organisation performance and the delivered care? Describe how this could happen?

Semi-Structured Questions for Nurses/Doctors:

1. Can you tell us about your role and duty in the organisation?
2. Could you tell us how is wound management and care work within your organisation?
3. What do you know about wound care specialist, are you familiar with their role? Do you have this speciality in your organisation?
4. Do you think having a specialised nurse in the skin and wound care could deliver a significant outcome for the patient, nurses and organisation? How, can you explain your answer?
5. In your opinion what a specialist nurse in skin and wound could provide more to the health services than general nurses?
6. Is developing wound management nurses can bring a negative or positive impact in the organisation? Explain your answer and describe how this can change your work?
7. How is your practice developed related to wound management, did you enter any specific course/training related to skincare and wound management? how do you think these courses will develop your skills or performance?
8. How do you think your learning skills and experience could affect your performance and decision making related to patient care? Do you think this will allows you to make a better decision than another profession in relation to wound management? Explain, please?
9. Do you think that nurses having sufficient knowledge that allows them to decide and manage wounds better than doctors? Why?
10. Is community perception and culture having a great influence on evolving your role? How?
11. What could be the organizational, cultural and contextual factors that impact your role to provide effective wound management?
12. How do you view your organisation's regulations and policies in relation to care delivery? How this policy influences your role?
13. What are the challenges that you encounter during your work?

<u>أسئلة لـ (المدراء)</u>

1. هل يمكن أن تخبرنا عن دورك وواجبك في مؤسستك ؟

2. كيف تنظر إلى سياسات ولوائح مؤسستك المتعلقة بالرعاية المقدمة ، كيف تعتقد أنها يمكن أن تعزز سلامة الجلد وإدارة الجروح؟

3. هل تعتقد أن تحسين حسن الإدارة الجيدة الجروح الجروح هي أن تكون معرفته من المؤسسة التعليمية ورؤيتها؟ كيف تعتقد أن هذا يمكن أن يحسن العناية بالجلد والجروح؟

4. هل تعتقد أن تضمين التدريب على العناية بالجلد وإدارة الجروح في التخطيط الاستراتيجي مفيد لنتائج المؤسسة؟ كيف يمكن أن يفيد هذا المؤسسة؟

5. هل من المفيد أن يكون لديك ممرضة متخصصة في إدارة الجلد والجروح في مؤسستك؟ لماذا ؟!

6. هل توفير ممرضات متخصصات في الجلد والجروح يمكن أن يسهل دور الممرضات في تنفيذ رعاية فعالة للمرضى ويقلل من عبء العمل على الممرضات والأطباء العاملين؟ هل يمكن ان توضح ذلك؟

7. هل تعتقد أن الممرضات لديهم المعرفة الكافية التي تسمح لهم بإدارة واتخاذ القرار بشكل أفضل من أي مهنة صحية أخرى تتعلق بإدارة الجروح؟ إشرح كيف؟

8. ما هي العوامل التنظيمية والثقافية والسياقية التي تؤثر على تنفيذ تخصص التمريض الجديد؟ كيف تعتقد أن هذه العوامل يمكن أن تؤثر على التخصص الجديد وكيف ستتعامل مع هذه العوامل؟

9. هل من المهم أن يكون لديك تخصص تمريض جديد في مؤسستك ، هل تعتقد أنه يمكن أن يكون مفيدًا كعامل مساعد في تنفيذ استراتيجية ناجحة لسلامة الجلد؟ كيف تعتقد أن هذا يمكن أن يحسن سلامة الجلد والعناية بالجروح؟

10. ما هي الفرص والتحديات الرئيسية التي تواجهها أثناء تنفيذ استراتيجية جديدة تتعلق بإدارة الجروح وسلامة الجلد في مؤسستك؟

11. هل تنفيذ برنامج جديد متعلق بإدارة الجروح وسلامة الجلد له تأثير سلبي أو إيجابي على أداء المؤسسة والرعاية المقدمة؟ الرجاء وصف كيف يمكن أن يحدث هذا؟

أسئلة للممرضات / الأطباء

1. هل يمكن أن تخبرنا عن دورك وواجبك في مؤسستك ؟

2. هل يمكن أن تخبرنا كيف التعامل مع الجروح داخل مؤسستك؟

3. ماذا تعرف عن أخصائي العناية بالجروح ، هل تعرف دوره؟ هل لديك هذا التخصص في مؤسستك؟

4. هل تعتقد أن وجود ممرضة متخصصة في العناية بالجلد والجروح يمكن أن يحقق نتائج مهمة للمريض والممرضات و المؤسسة؟ كيف يمكنك شرح إجابتك؟

5. برأيك ما الذي يمكن أن تقدمه ممرضة متخصصة في الجلد والجروح للخدمات الصحية أكثر من الممرضات العامة؟

وصف كيف 6. هل تنفيذ برنامج جديد متعلق بإدارة الجروح يمكن أن يكون له تأثير سلبي أو إيجابي على حياتك المهنية؟ اشرح إجابتك مع يمكن لهذا أن يغير عملك؟

7. كيف يتم تطوير ممارستك فيما يتعلق بإدارة الجروح ، هل شاركت في أي دورة / تدريب محدد يتعلق بالعناية بالجلد وإدارة الجروح؟ كيف تعتقد أن هذه الدورات ستطور مهاراتك أو أدائك؟

8. كيف تعتقد أن مهاراتك وخبراتك التعليمية يمكن أن تؤثر على أدائك واتخاذك للقرارات المتعلقة برعاية المرضى؟ هل تعتقد أن هذا سيسمح لك باتخاذ قرار أفضل من أي مهنة أخرى فيما يتعلق بإدارة الجروح؟ وضح من فضلك؟

9. هل تعتقد أن الممرضات لديهم المعرفة الكافية التي تسمح لهم باتخاذ القرار وإدارة الجروح بشكل أفضل من الأطباء؟ لماذا؟

10. هل الإدراك المجتمعي والثقافة لهما تأثير كبير على تطوير دورك؟ كيف؟

11. ما هي العوامل التنظيمية والثقافية والسياقية التي يمكن أن تؤثر على دورك في توفير إدارة فعالة للجروح؟

12. كيف تنظر إلى لوائح مؤسستك وسياساتها فيما يتعلق بتقديم الرعاية؟ كيف تؤثر هذه السياسة على دورك؟

13. ما هي التحديات التي تواجهك أثناء عملك؟

Appendix 3.2 Data Management Plan

Plan Overview

A Data Management Plan created using DMPonline

Title: The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

Creator: Fawzeyah Alharbi

Principal Investigator: Fawzeyah Alharbi

Data Manager: Fawzeyah Alharbi

Affiliation: Nottingham Trent University

Template: NTU PGR Data Management Plan

ORCID iD: 0000-0001-5877-9908

Project abstract:

The scope of nurses' knowledge has expanded and evolved as a distinguished profession where nurses can produce new knowledge. Now nursing has different areas of speciality such as tissue viability nurses, however, there is a gap in the professional role of nurses in Kuwait, Qatar, Jordan, and Egypt related to wound management and skin integrity. This research aims to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity in Kuwait, Qatar, Jordan, and Egypt, by understanding the concept of professionalisation related to nurses and skin integrity. This research used an exploratory qualitative approach to serve the research aim and provide an in-depth understanding related the absence of nursing specialisation in tissue viability in Kuwait, Qatar, Jordan, and Egypt, through the lens of professionalisation. A purposive and snowball sampling identified the relevant key decision makers and gatekeepers in the chosen countries such as hospital directors, nurses in clinical and administration positions, doctors, and policymakers. The primary data was collected using semi-structured in-depth interviews conducted between November 2021 to November 2022. A total of 32 interviews were conducted and explored the current and actual practices related to wound management and skin integrity in Kuwait, Qatar, Jordan, and Egypt. Thematic analysis was used for data analysis. A number of critical issues related to conducting research during the time of the pandemic and the impact of power on operations and organisational structure in the research are reflected on. The research findings contributed to understanding the wider structural, cultural, and social forces that influence on the development of the nursing profession, in Kuwait, Qatar, Jordan, and Egypt, and specifically to developing specialist tissue viability nurses. Furthermore, limits nurses' professional role related to wound management. Therefore, the findings from this research can be used as a reference for future research in similar areas from those countries or it can expand to other countries.

ID: 54061

Start date: 24-10-2019

End date: 20-04-2024

The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

1. Project details

Full name:

Fawzeyah ALHarbi

Unique ID:

N0881584

Provisional project title:

The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

Project start date:

2019-10-24

Project end date:

2024-04-24

Project context:

- Health studies in the college of health and social science.
- The research is an individual research project.
- It will take place in a Kuwait , Qatar, Jordan, and Egypt
- The data will be collected from (nurses, doctors, assistant directors of nursing, policymakers in the Ministry of health and Nursing Directorate, further, hospital and nursing directors).
- Kuwait Cultural Office provides full funding for the project.

1. Defining your data

Describe your data and how you will be working with it

- I will combine data from (In-depth interviews), then I will analyse the data thematic analysis, to draw a conclusion.
- Qualitative data will be collected electronically through the Microsoft team.
- The interviews will take place on (Microsoft teams), also the interview will be recorded through (Microsoft Teams).
- I will use the consent to ensure confidentiality and the participation information sheet to give more explanation about the research for the participants.

What formats and software will you use?

- Excel, Microsoft Word and PDF will be used to manage data.
- The audio recording will be used through (Microsoft teams) to save time and effort during the in-depth interview.
- I will use the NTU data store to save the recorded interviews in a separate folder, the data will be transferred to digital form, further, I will use my personal laptop to record the finding.

How much data do you expect to generate?

- The research will include various data will be gathered from Kuwait, Qatar, Jordan, and Egypt, approximately 60 images (jpeg/2 GB each).
- I expect to record 32 interviews for 30 to 40 minutes each, the output from these interviews will be stored in the NTU datastore.
- The data will be transferred to Mp3 then, will be saved and stored in a separate folder approximately (100 MB each).
- The hard copy properly will be saved in 1 cabinet with a lock until it can be digitized.

2. Compliance & data ownership

Is some/all data subject to any institutional, legal, ethical, or commercial conditions?

I will apply the consent and participant information sheet to ensure confidentiality and more explanation will be given about the research.

I will adhere to the following policies: NTU RDM policy, data security - portable devices and media policy, information classification policy, NTU records retention policy, NTU research ethics policy.

A formal agreement may be required with the participating from hospitals (TBC), this will be obtained through the Ministry of health Kuwait.

The DMP will be updated to ensure that the information complies with the terms and conditions of this agreement, formal or otherwise.

The management of data will comply with UK GDPR and data protection legislation in Kuwait.

What do you need to do to comply with these obligations?

- Data access to sensitive, personal and confidential data will be restricted to authorised individuals such as (myself and my supervisors).
- Published data must be protected minimally for 10 years.
- Confidential documentary evidence will be deleted or returned to participating hospitals.
- Consent will be obtained to allow plans for data retention and reuse (as described earlier).
- The personal and confidential data that I will be collecting will include name; contact details; job role; the name of the hospital that the participant works in. These data will be protected by putting a number of safeguards in place to protect participant privacy.
- Data will be pseudonymized, for example, interview transcripts will be labelled using a unique identifier/false name assigned to the participant.
- The participant and their contact details with the data obtained from them will be stored separately.
- By the end of the project, all direct and indirect identifiers that might disclose the identity of individual participants, as well as the hospitals, will have been removed.

Who owns the data?

The researcher and authorised people will own the data such as: NTU, supervisors, the ethics department in NTU, the Kuwait Ministry of Health, and other stakeholders.

3. Working with your data

Where will you store your data?

- Interview data will be captured securely using MS Teams.
- Any digital confidential, internal documents will be transferred securely.

- The individuals and hospitals may have a preferred method. If not, NTU ZendTo will be used to secure and encrypted transfer of confidential information.
- Upon receipt or generation, all data will be immediately transferred to the project's main storage on the NTU DataStore.
- Any hard copies of hospital documents will be digitized, then the hard copies will be destroyed.

How will you back-up your data?

- Using NTU Data Store for digital copies.

Who else is allowed to access this data during the project?

My supervisory team, the Social science ethics department in NTU has the right to access the data and authorised people from the Kuwait Ministry of Health.

How will you organise your data folders?

- The data will divide into separate folders based on the date and keywords.
- All the team members in the research should agree on the folder arrangements.
- I will use different classifications to differentiate between the group A and group B participants from Kuwait, Qatar, Jordan, and Egypt.
- I will use pseudonymized names, for example, using a unique identifier/false name assigned to the participant.

How will you name your files?

- Data collected from the hospital will be saved in separate folders for participant in group A or group B.
- The data will be saved in a folder based on the date of collecting the data.

How will you manage different versions of your files?

- I will use manual version control, by labeling files using V1, V2, FINAL so that I can easily distinguish between different iterations of my work.

How will you ensure your data is understandable to others?

- Avoid using difficult, unfamiliar or medical terminology.
- Using simple and common words for everyone.
- Use keywords for the abbreviations.
- Include a data inventory to outline the contents of the dataset, so that potential secondary users can easily navigate through the dataset.
- The data will also be accompanied by a readme.txt file that explains how data were labeled, versioned, and organized.
- Any other contextual information required to interpret the data, such a method of coding/ analyzing interviews, interview schedules etc. this will also be deposited with the dataset.

4. Archiving your data

What data should be kept, or destroyed, after the end of your project?

- According to NTU policy significant findings that supporting my thesis will be saved and will make it available to others as a resource for the relative topic. However, this will not include any personal, sensitive or confidential information.
- Any information relating directly/ indirectly to a participant will be removed, such as audio files and the pseudonym key linking participants to transcripts, as well as participants' contact details.

Where will you archive your data?

I will use NTU Data Archiveto archive the data.

When will you archive your data?

- Data will be deposited in the repository prior to my thesis being submitted for examination.
- Data that will be made publicly available (see Sections 5b and 5c) will be deposited under an embargo until the final, approved version of the thesis is submitted to IRep before the conferment of my degree.

How long will the data be archived for?

- In accordance with the NTU Records Retention Schedule, the research data will be retained for 10 years from the date of deposit.

5. Sharing your data

How will others learn that your data exists?

My data will be made discoverable in a number of ways:

- My thesis/ publication will include a data citation and data access statement, so readers will know where and how to access the underlying data.
- After depositing my project data in the (NTU Data Archive), I will register my data with NTU by submitting a PGR Data Registry Form.
- A metadata record for my research data will be created in NTU IRep. This record will offer a full description of my data, as well as linking directly to the record of my thesis. The thesis record will also link to the dataset metadata record so that people who locate my thesis will also be directed to its underpinning data.

Which data will be accessible to others?

- With the agreement of participating hospitals and the informed consent of participants, all archived data will be shared for purposes of ethically approved research.

Who will you share your data with and under what conditions?

Researchers affiliated with credible research organisations with ethical approval for the research that they intend to use the data for. At this point, it is hoped that data may be released under a permissive CC-BY license. However, this will be reviewed if the data are deemed to be potentially disclosive and/or sensitive.

How will you share your data?

The data will be available upon requests directed to the Library Research Team mailbox and only released in accordance with the terms and conditions stipulated upon deposit in the NTU Data Archive.

6. Implementing your DMP

How often will this plan be reviewed and updated?

My supervisory team and I will review this plan at interim, annual meetings and I will update as required.
The next review point will be when seeking ethical review for the proposed project to ensure that the informed consent of participants is sought.

What actions have you identified from the rest of this plan?

- Share DMP with supervisor and discuss before submitting.
- Arrange for secure storage on the NTU DataStore to protect confidentiality by submitting the Active Research Data Storage request form.
- Request access to research team data storage.
- Request for ethical approval from the ministry of health Kuwait prior to collecting the data.
- Clarify with participating hospitals if a formal agreement is required prior to data collection starting, or discuss with them how confidential data/ internal documents will be treated.

What support/ information do you need to complete these actions?

NTU LIBRARY RDMO.

Appendix 3.3 Ethical Approval, Informed Consent, and Participants Information Sheet

Fawzeyah Alharbi
Nottingham Trent University
School of Social Sciences
50 Shakespeare Street
Nottingham
NG1 4FQ

Dr. Imad El-Anis
Chair of the Schools of Business, Law and
Social Sciences Research Ethics Committee
Nottingham Trent University
50 Shakespeare Street
Nottingham
NG1 4FQ

Email: imad.el-anis@ntu.ac.uk
Telephone: +44 0115 848 3247

05 October 2021

Dear Fawzeyah

Application to Nottingham Trent University's Schools of Business, Law and Social Sciences Research Ethics Committee

Please accept this letter as written confirmation that your ethical application (no. 2021/115), entitled: *Exploring the strategy for the enablers and barriers to implement a skin integrity program at Kuwait,* was reviewed by members of the Schools of Business, Law and Social Sciences Research Ethics Committee (BLSS REC) and met with a favourable ethics opinion* on 30 September 2021.

Yours sincerely

I. El-Anis

Dr. Imad El-Anis
Chair of the Schools of Business, Law and Social Sciences
Research Ethics Committee
Nottingham Trent University

**Please note that the REC now provides 'favourable opinion' rather than 'approval', which was the term used previously. There has been no change to the scrutiny applied by RECs to research projects and the adjustment has been made to reflect more accurately the REC's role in considering ethical aspects of a project and concluding that all aspects are satisfactory from an ethics perspective. Other aspects of a project may (though not necessarily) still require attention before a project can commence, such as a risk assessment form, final research data management plan or relevant permissions from a third party.*

THE QUEEN'S ANNIVERSARY PRIZES
2015

Nottingham Trent University
50 Shakespeare Street, Nottingham NG1 4FQ
Tel. +44 (0)115 941 8418 www.ntu.ac.uk

Cali, Annabel
To: AlHarbi, Fawzeyah S H S 2019 (PGR)
Cc: Gibson, Linda; Chris Moffatt <christine.moffatt@hotmail.com>; Gorry, Jonathan

Thu 21/07/2022 10:07

(NTU) Ethical Application JUL... 214 KB
CONSENT (NTU) July 2022.d... 49 KB
Participant Information July 2... 44 KB

3 attachments (308 KB) Save all to OneDrive - Nottingham Trent University Download all

Message sent on behalf of the Chair of the Schools of Business, Law and Social Sciences Research Ethics Committee

Dear Fawzeyah

Thank you for the revised submission of your ethical application no. 2022/223 (amendment to 2021/115) to the Schools of Business, Law and Social Sciences Research Ethics Committee (BLSS REC) on 15 July 2022 requesting an ethics opinion for the project entitled: *Exploring the strategy for the enablers and barriers to implementing a skin integrity program in the Middle Eastern countries (Kuwait, Qatar, Jordan, and Egypt).*

Following resubmission, w e are pleased to inform you that the Chair was happy to verify that in their judgement, there were no outstanding ethical concerns and as a result, your revised application has meet with a favourable ethics opinion* through Chair's Action.

The favourable ethics opinion of your application is valid until **30 September 2023**. Should your project extend beyond this time then an application for an extension would need to be submitted to the BLSS REC.

Please note: your project has been granted a favourable ethics opinion based on the information provided in your application. However, should any of the information change at any point during your study or should you wish to engage participants to undertake further research, then you are required to resubmit your application to BLSS REC through the Worktribe Ethics Module for further consideration.

Receipt of a favourable ethics opinion does not constitute permission to proceed with the research. A 'breach of integrity' would technically occur if the researcher goes ahead with the project without the correct governance approvals being in place first, which could be considered to be Research Misconduct.

REC documentation should require an explicit commitment from research teams to consider the possible impact that any changes to their research project, but in particular changes to research design and methods of data collection, have on research ethics; and, therefore, whether a follow-up ethics review of a substantial amendment is required. If researchers are unsure, they should discuss the matter with their REC Chair in the first instance.

Examples of substantial changes that would require a research ethics application for review of a substantial amendment include:
(i) the safety or physical or mental integrity of the research participants (normally requiring amendments to information sheets, consent forms and other participant facing documents);
(ii) the scientific value of the study (normally requiring changes to the study methods);
(iii) the conduct or management of the study, (this might include changes in recruitment strategies, data management, or changes that might affect risk assessment);
(iv) the quality or safety of any equipment used in the study.

On behalf of the Committee, we would like to wish you success with the completion of your project.

Sent on behalf of
Chair BLSS REC

**Please note that the REC now provides 'favourable opinion' rather than 'approval', which was the term used previously. There has been no change to the scrutiny applied by RECs to research projects and the adjustment has been made to reflect more accurately the REC's role in considering ethical aspects of a project and concluding that all aspects are satisfactory from an ethics perspective. Other aspects of a project may (though not necessarily) still require attention before a project can commence, such as a risk assessment form, final research data management plan or relevant permissions from a third party.*

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دولة الكويت
وزارة الصحة
وكيل الوزارة المساعد لشئون التخطيط و الجودة

المرجع : 5226
التاريخ : 18/10/2021

To Whom it May Concern

From: *Ministry of Health – Kuwait*

The Standing Committee for Coordination of Medical Research

To: Fawzeyah Alharbi
NOTTINGHAM TRENT UNIVERSITY
Project Title:
Exploring The Strategy For The Enablers And Barriers To Implement A Successful Skin Integrity Program At Kuwait

(#1836/2021)

The above mentioned Proposal was given an ethical approval by the Committee on October 10, 2021.

The research will be conducted in Kuwait MOH.

Asst. Undersecretary for
Planning & Quality

Head, Standing Committee for Coordination of Medical Research

Ministry of Health – State Of Kuwait

د. فاطمة عبدالرحمن النجار
الوكيل المساعد لشئون التخطيط والجودة بالتكليف

CONSENT FORM

Project Title: The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

This project is part of a postgraduate study addressing the development of Tissue Viability Nurses through a partnership with Professors Linda Gibson and Professor Christine Moffatt and supported by Professor Jonathan Gorry at Nottingham Trent University. The study aims to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity in Kuwait, Qatar, Jordan and Egypt, by understanding the concept of professionalisation related to nurses and skin integrity. The research will explore the challenges associated with the nursing profession such as misunderstanding of the specialised nurse's role.

To achieve my research, aim and objectives I will use semi-structured in-depth interviews to explore the positions of various stakeholders in Kuwait, Qatar, Jordan, and Egypt, hence this will help to achieve the research aim and objectives. The respondent has the right to participate or to withdraw from this research at any time within 12 weeks from the date of the participation. The research will be confidential and by agreeing to participate in this research your information will remain confidential. By taking part in this research, you will be expected to take around 40 minutes up to one hour to finish the interview. Please feel free to ask any questions, Mrs. Fawzeyah Alharbi will be happy to answer your queries. Your participation is duly appreciated.

If you decided to participate in this research mark Tick (✓) for the following:

- I confirm that I have read and understood the research aim along with the information participation sheet. ☐
- I understand that taking part in this research is voluntary and I have the right to withdraw at any time within 12 weeks from the date of the participation without penalty and without having to give any reason. ☐
- I understand the research will maintain the confidentiality of the information that I have provided. ☐
- I confirm that my responses can be recorded and quoted anonymously for the PhD thesis. ☐
- I have been informed that there will be no payments for participation in this research. ☐
- I confirm that I want to be part of this research. ☐

Name of Participant...

Participant Signature ....

Date...

Name of Researcher...

Researcher Signature ....

Date...

Participant Information Sheet

1. Research Project Title

The professionalisation of tissue viability nurses in Kuwait, Qatar, Jordan, and Egypt

2. Invitation

This is an invitation to participate in this research project. Initially, before taking part in this research, it is essential for you to understand the background of the research, why the research is being conducted along with the potential outcome of the research.

Please, read the following information carefully, and if there is anything not clear do not feel hesitant to ask for more information. Take your time and based on your wish, you can decide to participate in the research or to withdraw.

3. What is the purpose of this project?

This study aims to explore the barriers and facilitators that influence developing specialist nurses in tissue viability and skin integrity in Kuwait, Qatar, Jordan and Egypt, by understanding the concept of professionalisation related to nurses and skin integrity. Furthermore, the study will explore the challenges associated with applying to the nursing profession such as misunderstanding of the specialised nurse's role and the contextual factors such as culture and gender that play a role in reforming the nursing profession.

4. Why I have been chosen to participate in this research?

Based on your experience and role in the organisation, you have been selected to contribute in this research, for example, nurses include (team leaders and head nurses), assistant directors of nursing, nurses directors, hospital directors, doctors, nursing directorate directors, individuals from policy department in the ministry of health will be interviewed.

Also, you have been chosen due to your knowledge of hospital services and regulations.

5. Do I have to take part in this research?

No, according to your wish if you have decided to participate in this research or not.

Remember* that you have the right to withdraw from the research at any time within 12 weeks from the date of the participation. In the case of withdrawal, the respondents will be able to contact the researcher using the contact details that will be provided prior to the interview. Then, the researcher will remove the data of the particular respondents.

If you are willing to be involved in this research, then you need to have a copy of this information sheet. Furthermore, you must show your agreement on the consent form.

6. What could happen to me if I decide to participate in this research?

When you decide to take part in this research you will be asked to participate in the semi-structured interview, which could take 40 minutes up to 1 hour approximately. Furthermore, you may agree to a follow-up interview in order to understand more about the research approach which can be last for 40 minutes.

7. How and where the interview will be conducted?

A face-to-face interview is limited due to the pandemic of COVID and associated health restrictions, the interview will be conducted virtually with the participants through (Microsoft Teams).

8. What should I do after I decide to take part in this research?

Please answer the sections in the semi-structured interview and ensure your availability for future correspondence.

9. What are the possible risks or disadvantages of participating in this research?

By taking part in this research you will not experience any signs of psychological or physical discomfort or stress. Despite this, the ongoing work commitments can make it difficult to engage in the interview with sufficient time.

10. What are the possible advantages of participating in this research?

By participating in this research there will be a benefit from a knowledge perspective which can produce a significant advantage for the nurses and other healthcare providers. Besides, the knowledge that will be acquired by participating in the research can be shared with peers while ensuring confidentiality. However, no monetary benefit can be offered.

11. What could happen if the research study finished earlier than what expected?

If the research is finished earlier than the plan, we will let you know, and we will explain why the research was finished earlier. However, it is not anticipated that the research will be finished earlier than what expected due to the pandemic of COVID-19. If the research is finished earlier then it will enable the participants to receive the research outcome earlier than expected at the point of the interview. Moreover, it will also enable the participants to ensure from the published research that their anonymity has not been compromised.

12. What if something unexpected or wrong happened?

If you feel something going wrong in the research, you can contact any member in the research team for further information and assistance. You can also contact the Nottingham Trent University support team if you feel that the research team were unable to solve your issue carefully.

13. Will my participation in this project be kept as confidential?

The information that will be gathered from you will be kept confidential in a separate file; only authorised individuals can have access to the data such as: the supervisors. Moreover, Nottingham Trent University's data management plan will be followed to deal with data, further, the research will use a pseudonymised name to protect confidentiality while dealing with the collected data. The collected data might be shared and used in an anonymised form by the research team. The data will not be identifiable by any organisation or individual.

The aforementioned of using pseudonymised names will help in ensuring anonymity even if the comments will be used verbatim. The transcript will be retained and maintained in an anonymised form.

14. Is recording compulsory in this research, if so, then how the recorded media will be used?

The interview will be recorded, and it is part of the consent form which requires your agreement to take place in this research. In accordance with the NTU Records Retention Schedule, the transcript will be retained for 10 years from the date of deposit. Further, audio recordings of interviews will be destroyed by the end of the project. In addition, to destroy the retained data I will follow NTU data management guidelines.

15. Is there any specific information that will be obtained from me and how this information is relevant to the research objectives and aim?

The interview questions will include some information related to your work such as the advantages and challenges of your work, and further, your work responsibilities and roles. All the information that will be collected from you will help the researcher to explore more about the profession.

16. How the results of the research will be handled and what will happen to these results?

The results of this research will be used by Mrs. Fawzeyah Alharbi as part of her research project. The result will be published in academic works, with ensuring the confidentiality of your data, nothing related to you or your organisation will be identifiable. I will share the knowledge about the research if any update through email. Further, based on your preference a copy of the research report can be shared with you, just let us know if this is required.

17. Who is responsible for funding this research?

This project has funding from the Kuwait Cultural Office through a partnership with Professors Linda Gibson, Professor Christine Moffatt and Professor Jonathan Gorry at Nottingham Trent University.

18. Who has reviewed and approved this research ethically?

Nottingham Trent University research ethics committee team have reviewed and approved the research project ethically.

19. For further information feel free to contact the following:

Mrs. Fawzeyah Alharbi, Post Graduate Researcher. N0881584@my.ntu.ac.uk

نموذج اقرار الموافقة

عنوان البحث: استكشاف استراتيجية للعوامل المساعده والعوائق لتنفيذ برنامج سلامة الجلد في مستشفى جامعة نوتنغهام ومركز صباح الأحمد لجراحة المسالك

يعد هذا المشروع جزءًا من أبحاث الدراسات العليا ، والتي ستتناول نظام إدارة العناية بالجروح في قسم المسالك البولية / مستشفى

جامعة نوتنغهام - المملكة المتحده ومركز صباح الأحمد لجراحة المسالك – الكويت. علاوه على ذلك ، ستركز الدراسة على تحديد العوامل المساعده والعوائق لتنفيذ استراتيجية تتعلق بالجروح وسلامة الجلد داخل مستشفى جامعة نوتنغهام ومركز صباح الأحمد لجراحة المسالك. يجري البحث في المملكة المتحده والكويت ، من خلال شراكة مع الأستاذه كريستين موفات ، والدكتوره ليندا جيبسون في جامعة نوتنغهام كرنت والدكتوره سو هيذر في مستشفى جامعة نوتنغهام. سوف يستكشف هذا البحث التحديات المرتبطة بتطبيق مهنة التمريض مثل سوء فهم دور الممرضة المتخصصة

تعد المقابلة والاستبيان أداه يمكن أن تساعد في استكشاف رأي أصحاب المصلحة في الكويت و المملكة المتحده وبالتالي سيساعد ذلك في تحقيق هدف البحث.

سيكون التعامل مع المعلومات في البحث بشكل سري وبموافقتك على المشاركة في هذا البحث ، ستظل معلوماتك سرية. يحق للمشارك الانسحاب من هذا البحث في أي وقت. من المتوقع أن تستغرق حوالي 15 دقيقة للانتهاء من هذا البحث. لا تتردد في طرح أي أسئلة ، وستكون السيده فوزية الحربي سعيده بالإجابة على استفساراتك. شاكرين لك مشاركتك في البحث

إذا قررت المشاركة في هذا البحث ضع علامة ✓ على ما يلي

- -أؤكد أنني قد قرأت وفهمت المعلومات السابقة ☐
- -أفهم أن المشاركة في هذا البحث تطوعية ولدي الحق في الانسحاب في أي وقت دون عقوبة ودون الحاجة إلى إبداء أي سبب ☐
- -أفهم أن البحث سيحافظ على سرية المعلومات التي قدمتها ☐
- -أفهم أنه يمكن تسجيل ردودي ونقلها دون الكشف عن هويتي ☐
- -لقد تم إبلاغي بأنه لن يكون هناك مدفوعات للمشاركة في هذا البحث ☐
- -أؤكد أنني أريد أن أكون جزءًا من هذا البحث ☐

اسم المشترك ....

توقيع المشترك ....

تاريخ ....

اسم الباحث ....

توقيع الباحث ....

تاريخ

Appendix 5.1 Dressing Policy

State of Kuwait Ministry of Health Department of Nursing Policies and Procedures Approved: Quality Assurance Committee.	Title: Wound Dressing
	Section: L - Aseptic Technique
	Procedure # L - 52
	Date Effective: Dec 2003

Definition:

Cleaning, treating and covering of a wound aseptically.

Goal:

To promote healing and prevent complications.

Equipment:

Trolley containing:

1. Sterile dressing pack with:
   a. Three (3) pairs of forceps.
   b. Two (2) Gallipots.
   c. Cotton balls.
   d. Gauze pieces.
2. Hand disinfectant.

1. Cleaning solution.
2. Tray containing:
   a. Adhesive plaster
   b. Pair of scissors.
   c. Bandages.
3. Masks.
4. Sterile gloves.
5. Bed protector.
6. Container for waste.

Optional:

Antiseptic solution.
Ether.
Pair of sterile scissors.
Prescribed medication.
Gown.

Steps:

1. Confirm doctor's instructions.
2. Wash and dry hands.
3. Clean, dry and disinfect the trolley.
4. Assemble equipment and bring to the patient.
5. Identify the patient and explain the procedure.
6. Position the patient appropriately.
7. Wear mask.
8. Disinfect hands.
9. Open sterile dressing pack.
10. Pour appropriate solutions.
11. Remove and discard outer dressing.
12. Disinfect hands.
13. Wear sterile gloves.
14. Remove the inner dressing with sterile forceps and discard both.
15. Take the soaked cotton ball with sterile forceps, wring out and transfer to the forceps in the other hand.
16. Clean the wound from inside to outside using separate cotton ball for each stroke
17. Dry the wound and apply the prescribed medication, if any.
18. Cover the wound with dry gauze.
19. Remove gloves.
20. Secure the dressing with adhesive / bandage.
21. Make the patient comfortable.
22. Discard waste and replace reusable equipment.
23. Wash and dry hands.
24. Document necessary information.

Refer to general instructions on page - 9.

Developed by: Procedure Committees.
Approved by: Steering Committee of Nursing Quality Assurance.
Date: December 2003

Collection

Group B /

K

Nono	Tintu	Rinshu	Rincy
1. I am working in a male urology ward as an acting head nurse, since 2011 till 2021 I was a team leader in uro-surgery department, my background is general nursing. I have 18 years of working experience in Kuwait. 2. Okay, here we are doing dressing based on the doctor's orders. We initially do the assessment for the patients, this include checking the skin condition, if there is a blister or bed ulcer we write it in the assessment sheet and write it in the (Decubitus ulcer sheet). Then after that we inform the charge nurse and the supervisor in the shift, at the same time we will inform the doctor responsible for the case. After that, the on-call doctor will come to check the wound and write his	1. I am working in OPD as acting head nurse. 2. In OPD we are assisting doctors in dressing inside the clinic, we have two dressing room for both male and female. In dressing room we open the sutures, changing dressing and follow the OPD policy. For changing the dressing no need for the doctor to cheack usually they send them to the dressing room after discharge form the ward or directly from the clinic. 3. I am sorry I have no ideas about there role, do you mean ATC nurses, In OPD for sure we do not	1. I am a team leader in the outpatient department. 2. We have 2 dressing rooms, 1 for male and 1 for female. Usually, nurses are the ones changing the dressing. But in some complicated cases or VIP patients, doctors are doing dressing for them. 3. The ones working in the dressing room are general nursing including me I was assigned in the dressing room, and we do not have specialised nurses for wound care, only general nurses. 4. Not at all, especially during the pandemic. This nursing speciality will increase the workload. And those nurses will not be able to help us. 5. I think general nurses doing more effort than specialised nurses. We can do anything for patients but special nurses will do dressing only then we will	1. I am working as a team leader since 2016, but also I am doing the duty of a general nurse to cover staff shortages. as a team leader. 2. Doctors are the ones who instruct us by writing in patients' files their orders then we will follow the order. 3. Yes, I know about this speciality from my home country, I know they are responsible for checking the wound and dressing. In Kuwait, since I came here I did not see or heard of this speciality. 4. Yes, very important to have a specialised nurse for wounds because they are focusing on a particular area, so they can give better care then met patients' needs. Also, they can teach other nurses. 5. In my view, specialised nurses can improve the

Group B /

Q

Mercy	Peena	Saramma	Nivedhitha
1. charge nurse in the Uro-surgery ward 2. cleaning wounds and doing the assessment, 3. the specialist nurses in wounds. 4. Yes, for sure. 5. The specialised nurses, in my opinion, can give better care to skin and wound management, they improve the **quality of care.** 6. I think positive. Sometimes, I find it difficult to keep reading all the time but I challenged myself I see how in Qatar nurses have voices and no one can insult us	1. general nurse working as, a staff nurse at bedside and in orthopaedic department for around 18 years, total experience now, 23 years 2. We have special nurses for wounds 3. if have patients with complicated wounds, they will do dressing and then telling us how to clean it, if we need them out of their shifts. 4. For patients yes, they can do dressing and assessments, they knows different material for wound dressing they are expert in wounds. Its ok for nurse we can manage even without them, at the end all of us are qualified nurses.	1. I am working approximately 20 year urology department. I have 25 years experience, 3 in India remaining in Qatar 2. we have special staff for wounds and they are responsible for doing dressing. And general staff they are doing basic nurses' duties. 3. Yes, as I said we have they are like consultants this what they call them , if we receive patients with infected wounds we will inform them and they will assess the wounds and doing dressing. Good to have different speciality but staff should be enough Its good for patients, but for nurses more work. uh, like for	1. yeah I'm 31 from India, I did my BSN (Bachelor) in 2013. Total. I have eight years experience in MCU (medium care unit) and SCU (special care units) like OPD department. 2. Actually we are doing assement for the wound then dressing, we asses if there is signs of imflamation or infection. 3. Yes, actually we are thinking that we have one in Secretary place. We tries. I'm trying to tell my opinion to my director of nursing. 4. No, no, only one triage nurse is enough for us. Because already we have 15 years experience, 17 years experience, Sister staff is with me now. We do not need them, because we have small department, may

Group B/

J

TAQI M.	Saja	Taha	Mohanad	Huda
1. emergency DEPARTMENT. 2. checking the wound and assessing the wound before the doctor. Then the doctor will diagnose. 3. I saw those nurses in Australia while I was working. Also, in Jordan, we have a nursing speciality in skin and wound management. 4. those nurses are usually with master's degrees. 5. specialised nurses are more skilful in their area of speciality. 6. Yes, could bring a positive	1. in ICU 2. doing dressing and assessment for the wound, In most cases we are stitching depending on the wound, and if the doctor is not available. 3. No, we do not have specialised nurses, we have nurses with diplomas and Bachelor's degrees in ICU, for nurses with bachelors we can do the stitching for wounds and can be in management positions. Also, we have higher studies such as	1. clnical instructor for 4 years, in the OT, I have 12 years experience. 2. we do check the wounds after surgery in the recovery room and if there is oozing we inform the surgeon directly to take an action. 3. nursing speciality in wounds in the private sectors. WE HAVE general nurses and midwivery. 4. I did not work with them but I think this	1.a clnical instructor for 4 years, in the Nursing college, then about 8 years experience in King Abdullah Hospital. 2. We have special nurses for wounds care and they usually doing dressing, assessing wounds, they are like a consultant if there is any problem in skin usually we contacting them. 3. but in my organization we have all thespeciality for example for: quality nurses, infection control nurses, skin speciality nurses. 4. yes, of course, 5. Both are providing good services, 6. I think for any	1. I worked 7 years with diploma in nursing and 2 years with Bachelour degree in nursing. 2. We are following doctor order in cleaning the wounds, 3. We have in my organisation specialised nurses for wound care, 4. Yes, Those nurses will give special care for dressing and wound, Like they will have more knowledge than other nurses in wound, because they studied more, and all of them they have master degree. 5. No both are doing there job even doctors, all of us in the hospital doing our job, I cannot interfere in doctor job and he cannot ask me to do his job all has

Group B

E

Abdulatti	Ahmed	Thamer
1. Head nurse 2. we have specialised nurses in the wound. 3. their role is very significant to enhance the healing process and patient recovery. 4. I do not think here the specialising nurse is a good idea, 5. Of course, this will bring a positive impact because they will have more awareness about wound care, and their knowledge is constantly updated related to the area of speciality. It can be negative also if there is nursing shortage and those specialised nurses are not familiar with other aspects of patient care, hence, we cannot benefit from them in case of emergency. 6. Training is part of our organisation, and you will find staff development unit always	1. charge nurse 2. have specialised nurses. 3. Those nurses have their own clinic with the approval from the ministry of health, they have a license for the clinic. We have an area (AlAathamiya) for those specialise nurses for wounds and fractures. 4. Yes, of course, as I told you here we have trust in the nursing profession, people do respect nurses if someone has a wound will go to the nurse not to the doctor to diagnose him. 5. specialise nurses are more skilful in their area of speciality. 6. it cannot be negative because those nurses will give better care to patients and patients can go home without complications. 7. Honestly, more than the training we have here practise, this practice makes the nurses expertise in their work. Like, in my area we have (a tribe system) so it is common to have injuries due	1. general nurse 2. We don't have specialised nurses (in the organisation). 3. we are general nurses but we receive training to work in this clinic. We are working with football players and every day receiving injuries, and wounds care is the main part of our duty. 4. Yes, of course, will reduce the workload for other nurses. Any speciality if we have apart from nurses' specialities, will help to improve the care. 5. Yes, like what I said earlier specialised people will have more knowledge than general nurses.

Group A/

K

Waleed	Hassanin	Hussam
1. paediatric consultant, and head of the paediatric department. 2. One time I will do it for the patients then they will follow, usually they follow our instructions. 3. I saw specialized nurses in Australia and Canada but in Kuwait, I did not see them. 4. Providing specialized nurses will reduce the workload, and then the hospital services will improve. 5. Yes, of course for example in Canada they have special nurses she is the one doing urodynamics, also they fixed foley catheters. Not like here. 6. I think it will bring benefit to the organisation as I said nurses doing urodynamic and other specialists such speciality in wound management and skin will reduce the work overload and they have the ability to teach the patients how to take care of the skin so the patient will not have a complication in the skin then will not come to the hospital frequently. 7. Yes, they have the knowledge, but I did not see any nurse discussing the treatment plan with me,	**1.** an assistant manager in my organisation. **2.** The policy is available but needs to be updated for nurses, the available policy needs some work to enhance nurses' role in the organisation. **3.** Vision is important to improve the staff's ability, and help to achieve organisation's goal. Alonge with enhances nurses' role in the organisation. **4.** Yes, for sure it is beneficial to provide training that will improve nurses' skills. Then those nurses will help to give intensive care to wounds. In addition, patients will recover earlier. **5.** Yes, of course, this could help to improve nurses' skills, especially in the area of skin and wound management. **6.** The provision of specialized nurses will decrease the workload and will reduce doctors' workload also, especially when we have a shortage of doctors. **7.** Some nurses have the knowledge to write the treatment plan and can decide on wound care based on their	1. I am responsible to manage 6 hospitals, before that, I was responsible for 1 general hospital (AlAdan) and 4 specialized center (Kuwait cancer center, Palliative center, Ibn- Sina for neurological disease). I was working with a team to provide training and follow up- for the hospital's medical staff and make sure the staff are following the policy and strategic plan of the organisation. I took the role of a quality director in (Mubarak hospital). 2. In the private sector, there are specialized nurses, in the government sector also there are nurses working in the diabetic foot clinic but not sure if they are receiving training or based on what there are selecting those nurses. 3. Already everything is written in the policy and guidelines, ... We do not want to increase the paperwork and write it again and again, mmm,... but we need direct participation from the ministry of health to train those people in Kuwait. No need to spend a lot of money to bring specialised people from outside the country but