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Formation of a Nursing Theory on Nursing Improvision

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Abstract

Nursing practice often occurs within increasingly complex, unpredictable and resource-variable environments demanding adaptive, creative and context sensitive responses. While evidence-based protocols and standardized guidelines guide much of the nursing care of the present day, the frontline nurses frequently in improvised actions that aim at maintaining their safety, continuity and therapeutic effectiveness. Despite its prevalence, improvision in nursing is under-theorized and little conceptualized in formal knowledge systems in nursing. This literature-based paper proposes the formation of a Nursing Improvision Theory that recognizes improvision as a legitimate and structured dimension of nursing practice rather than informal work-around behavior, that is ethically grounded. Drawing from the literature on adaptive expertise, clinical judgment, complexity science, resilience, innovation in care delivery, and practice theory, the paper draws on conceptual foundations for theorizing nursing improvision. The article presents a review on eight subtopics: conceptual understanding of improvision as applied to clinical practice, historical development of adaptive nursing practice, improvision and clinical judgment, complexity and uncertainty of care environments, constraints of resource and creativity in action, ethical boundaries for improvised care, organizational and educational factors, and statements of outcomes for improvised nursing interventions. The theoretical structure posited identifies core constructs and relational propositions and implications for practice. The theory establishes nursing improvisation as a professional, ethical, competent, adaptive, patient-centered process. Developing this theory adds to the science of nursing by legitimizing adaptive action, training, enhancing safety frameworks, and informing resources policy in resource variable health systems.

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Introduction

Nursing practice is well known as a science and an art that integrates standardized clinical knowledge, situational responsiveness, and relationship related care. While the structure of modern nursing intervention-including pre-set protocols, guidelines, and a base of evidenced interventions-constitutes much of the backbone of nursing care, the clinical ambitances within which practitioners operate are often in conjunction with unpredictable circumstances that do not have to be completely fixed by set procedures. Nurses are regularly confronted with situations in which uncertainty, lack of information, time pressure, and material constraints, forcing nurses to be flexible and improvise to ensure patient safety and continuity of patient care (Benner, Sutphen, Leonard, & Day, 2010; Klein, 2015).

Improvisation or impro, in the context of nursing, is the contextual, creative, and adaptive actions taken in the absence of what is considered standard pathways, not because they are unavailable or unsuitable. While such moves are frequently commonplace in practice, the use of informal language of "workarounds" and deviations from protocol are more often than not branded as little more than skilled professional responses (Tucker & Edmondson, 2003). This framing has the tendency to underestimate the adaptive expertise of nurse practice and masks the understanding of a dimension of clinical reasoning and action which is important. Nursing scholarship has provided ample theoretical thinking on caring, adaptation, interaction of systems and clinical judgment, but has not led to a unified, middle range, or practice theory that is focused on improvised nursing action. Healthcare systems are becoming more complex, high-tech, and resources are uneven, particularly in low- and middle-income settings and in settings of high demand care. Complexity theory suggests that pure proceduralism will not ensure effective care in such systems, for both the ability of systems to change in the moment (adaptive capacity) and ability to turn problems into solutions (problem solving) are critical (Plsek & Greenhalgh, 2001). Therefore, theories on nursing improvision is not just an academic experience but a necessity in lining up the nursing knowledge with the real practice situation.

A literature-based foundation for a Nursing Improvement Theory is developed in this paper. This is a synthesis of interdisciplinary and nursing literature to specify the constructs and potential drivers and generate relational propositions to explain when and how improvision happens and how it may be done safely and ethically. The goal of this is to move improvisation from a hidden reality in the practice world into a theory that is examined in the visible world.

Concept of Nursing Improvision

Improving in the craft is commonly indexed to be deliberate action living away from standard procedure in light of situational demands even though pushing for legitimate goals (Weick, 1998). In healthcare, improvisation has been defined as adaptive performance in conditions of uncertainty in which practitioners recombine available knowledge and resources in order to solve emergent problems (Ciborra, 1999). Within the field of nursing this phenomenon can be observed in bedside adjustments, in the redesign of workflow, in patient communication and in the substitution of resources. Benner's model of novice to expert practice underscores the fact that expert nurses critically depend on their situational perception and tacit knowledge to respond flexibly in situations other than rule-based behavior (Benner et al., 2010). This is close to improvise practice where pattern recognition and experiential knowledge is the path of rapid adaptation. Similarly, Schon's concept of "reflection-in-action" refers to the way that professionals think and act in changing situations at the same time and adjust interventions in a dynamic way (Schon, 1983).

Importantly, improvision is different to unsafe deviation. The literature distinguishes between mindful adaptive variation and shortcuts that result in errors. Adaptive variation is based on professional judgment and intent focused on the patient; unsafe shortcuts are based

on convenience or pressure imposed by the system itself (Reason, 2000). A nursing theory of improvision has to expressly integrate ethical reasoning and safety orientation in differentiation of legitimate improvised care from negligent practice. Emerging work on resilience engineering in healthcare also supports this distinction, with a focus on frontline clinicians who actively modify processes in order to maintain system functioning in a safe way under variable conditions (Hollnagel, Wears, & Braithwaite, 2015). Nurses, as consistent providers of care to patients, are key players in such adaptive processes. Thus, nursing improposition can be conceptually defined as: a competent and ethical modification or production of nursing action in response to context undertaken for a patient-centered outcome, because standard procedures are inadequate and infeasible.

Historical Evolution of Adaptive and Improvised Nursing Practice

Adaptive action has always been embedded in nursing work even if not to be called improvision. Early models of nursing focused on responding to the needs of patients in limited settings. Nightingale's environmental approach, for instance, implicitly supported situational modification, or contextual observation-based modification of ventilation, hygiene, light, and other nutrition-related conditions, rather than strict procedures (Nightingale, 1860/1992). This is an early type of observation-based and purposeful structured improvised care. As nursing became a professionalized field throughout the twentieth century, the level of standardization was raised through protocols, checklists and procedural manuals. While this standardization enabled safer and utzy practices, it also altered professional discourse such that it focused on compliance matters and decentered on creative adaption (Timmermans & Berg, 2003). Nonetheless, ethnographic and practice-based studies continued to demonstrate that nurses continued to alter, re-interpret, and tailor procedures differently to meet patient needs in real time. These micro-adaptations often were not visible in the formal documentation but were at the core of the care delivery (Allen, 2014).

More protocols with the rise of evidence-based practice more protocol-driven care models. However, scholars noted that the application of evidence is never purely mechanical, but requires the concept of context and clinical judgement (Greenhalgh, Howick, & Maskrey, 2014). Nursing scholars were starting to recognize increasingly the existence of the "practice gap" between the recommendations in guidelines and the actual practice of the medical profession, where practitioners must balance general recommendations with particular patient conditions. More recent ultra-safety and resilient literature puts frontline adaptation into perspective, as a system strength, not a deviation. Resilience engineering suggests that safety in healthcare is not just a matter of ensuring there is no error but of accommodating the capacity to adapt (Hollnagel et al., 2015). Within this paradigm, nurses are acknowledged as continual care process adjusters. This intellectual shift allows for the theorizing of improvision as a professional competency and not an informal workaround behavior.

Thus, within the historical trajectory, there are three stages: TAC (tacit adaptive care); PF (protocol-dominated formalization); and AEC (adaptive expertise emerging recognition & recognition). A nursing theory of improvision logically expands on this third phase by explicitly modeling adaptive practice as structural, skilled and worth theorizing about.

Improvision and Clinical Judgment in Nursing

Clinical judgment is one of the most established constructs of nursing scholarship and offers a critical anchor of theorizing provision. Clinical judgment is about noticing, interpreting, responding and reflecting in patient care situations (Tanner, 2006). Each of these phases includes possible points where improvised action may arise - especially where the cues are not conforming to regular patterns and where options for response may be limited. Benner et al (2010) have shown that expert nurses do not work from mostly abstract rules but situated understanding and pattern recognition. Expert performance often includes the flexible departures from the textbook sequences because the practitioner is aware of the nuances of

the context. Such departures are not arbitrary: they are based on deep knowledge from experience. Improvement: Seeing improvisation in terms of the variation based on judgment can be conceptualized.
Naturalistic decision-making research also reveals that experienced practitioners draw on recognition-primed decision processes when time is of the essence and generate workable actions quickly without having to compare multiple formal options (Klein, 2015). In acute care settings, nurses often work under such cognitive conditions. Improvised adjustments (changing patient positioning in the context of delayed equipment, substitute communication strategies in the context of communication barriers, changing the sequence of interventions in the context of instability) reflect this mode of decision. Reflection-in-action is yet another support for the cognitive basis of improvision. Schön (1983) explained dynamic testing and modification of actions as a situation unfolds for professionals. Nursing simulation research also illustrates that flexible people are better than strictly rule-bound people at responding in complex circumstances (Benner et al., 2010).
However, there are also warnings in the literature that the variation based on judgment needs to be underpinned by metacognition and reflective capacity. Without reflective grounding, improvisation can often appear either inconsistent, or it can be unsafe (Tanner, 2006). Therefore, a theory of nursing improvision needs to incorporate clinical judgment as one of its core enabling constructs and reflection as a regulatory mechanism.
Healthcare systems are increasingly being labeled as complex adaptive systems featuring nonlinear interactions, emergent behavior and unpredictability (Plsek & Greenhalgh, 2001). In such systems, it is not always possible to obtain results by executing a protocol linearly. Instead, practitioners have to adjust to the changing variables constantly such as patient response, team dynamics, technology reliability, and organization constraints. Complexity science makes a suggestion that Max Weber was right - because dynamic systems cannot be standardized strictly enough in order to anticipate all possible states. Adaptive capacity is therefore a critical performance variable (Braithwaite, Churruca, Ellis, Long, & Clay-Williams, 2017). Nurses, as the light stands between patient, technology, and flow, are the major drivers of such adaptation.
Uncertainty is also epistemic - clinicians usually perform with incomplete information. The previously mentioned difficulties of diagnostic ambiguity, the changing of symptoms, and the delay of test results from the test lead to decision gaps. Under these conditions, interim actions are often required, which must be improvised to be able to stabilize patients and/or ensure continuity of care (Klein, 2015). Research in emergency and critical care contexts documents many micro-innovations and situationally adaptable adjustments of nurses to bridge uncertainty periods (Allen, 2014). Work system variability is further reason for improving. Staffing shortages, equipment failure and limitations to supplies mean that nurses sometimes need to reconfigure processes on the fly. While in traditional models of safety these could be considered deviations, models of resilience consider them an adaptive adjustment toward maintaining function (Hollnagel et al., 2015). Importantly, complexity theory highlights the adaptive action of system goals, feedback, and not random variation. Therefore, nursing improvision needs to be conceptualized as goal-directed adaptation between professional standards and ethical commitments. This should give the theoretical legitimacy without losing the accountability.

Resource Constraints and Creative Nursing Action

Resource variability is a constant throughout health care systems and is most marked in low-resource settings, emergency settings, and rural facilities and high-demand units. Nursing literature consistently demonstrates that when the material, staffing or technological resources is not adequate, nurses practice the creative recombination and substitution of resources to ensure continuation of the delivery of patient care (World Health Organization,

2020; Allen, 2014). These practices often manifest themselves in the form of improvision. Studies of the work processes of nursing have shown that frontline workers frequently redesign work processes and adapt tools on the fly when official resources are unavailable or not yet arrived. Tucker and Edmondson (2003) wrote about how nurses routinely create "first-order problem solving" fixes-at the moment, in the area where it happened, a way for the care to continue even though something about the system has gone wrong. Although sometimes termed as workarounds they may be by skilled adaptive responses rather than careless deviations.
There is also an innovation literature in nursing that supports creativity under constraint can lead to effective care strategies. Frugal innovation models explain the process of how practitioners will create low-cost and high-impact solutions from recombination of available materials and knowledge (Bhatti, Taylor, Harris, Wadge, & Escobar, 2017). In community and public health nursing, adaptive improvisation is frequently required to contextualize interventions from a cultural, infrastructural and economic perspective.
However, an important distinction has been made in literature between resourceful adaptation and risk-amplifying substitution. Creative action must be clinically appropriate and aware of its safety. When improvisation is prompted for no other reason than resource scarcity (and there is no sufficient competence nor evaluation), patient risk is elevated (Reason, 2000). Therefore, a theory of nursing improvision had to place resource constrained creativity within competency, risk assessment and outcome monitoring structures. This collection of research argues for the inclusion of resource constraint as a key contextual trigger variable in a theory of nursing improvision and creative recombination as a fundamental process mechanism.
Any theoretical approach to the provision of nursing must address the issues of ethics and accountability explicitly. Nursing is a regulated profession that is based on the ethical codes focusing on beneficence, non-maleficence, patient autonomy, and justice (International Council of Nurses, 2021). Improvised action, in definition, must be adjudged outside standard procedure, leaving issues raised regarding the professional legitimacy and moral justification of action. Ethics literature in clinical decision making acknowledges that black-and-white rule-following is not always ethically optimal in cases where the circumstances are complex. Instead, moral agency demands context sensitive judgment (Schön, 1983; Tanner, 2006). Nurses are often faced with ethical dilemmas between following protocols and meeting the specific needs of the patients. In these circumstances ethically informed improvision may be better for patient welfare than mechanical compliance.
Improvised nursing action does not take place in a vacuum - it is shaped by organization culture, leadership style, climate, and educational preparation. Research on high-reliability organizations demonstrates that high-reliability organizations are safer when they have cultures that encourage mindful reporting, learning, and flexibility as opposed to those that are rigid and blame-oriented (Weick & Sutcliffe, 2015). Organizational quiet and disciplinary responses to deviation discourage transparent adaptive action and subterranean improvisation, where it can not be assessed and redesigned. In contrast, frontline adaptations are viewed as data by the learning-oriented cultures for improving the system (Braithwaite et al., 2017). This distinction is important in theorizing improvisation as either hidden workaround behavior or recognized adaptive expertise behavior. Leadership also plays the mediating role. Transformational and relational forms of leadership and psychological safety are linked with increased psychological safety, which allows clinicians to exercise judgment and bring up situational issues (Cummings et al., 2018). Whereas where nurses feel psychologically unsafe, they are likely to strictly play it by rule even under inappropriate circumstances, or they will improvise alone without consultation from other peers - both of which are undesirable extremes.

Educational preparation is also a determinant. Argued by contemporary scholarship, traditional nursing education focuses more on procedural strength and following protocols, requiring more emphasis on adaptive expertise, on implementing historical thinking, and in addition to simulation-based complexity training (Benner et al., 2010). Simulation pedagogy has been found to enhance flexible clinical reasoning and real-time adjustment skills. Adaptive expertise differs from routine expertise: the former are able to do things with high efficiency under stable conditions, while the latter is able to innovate under changing conditions (Hatano & Inagaki, 1986). A nursing improvision theory should therefore have adaptive expertise development as a foundational antecedent variable. Continuing professional development, reflective practice models and debriefing systems provide further support to safe improvision to make individual adaptive acts shared organizational learning (Schön, 1983; Weick & Sutcliffe, 2015).

Core Constructs and Relational Propositions of Nursing Improvision Theory (NIT)

The proposed Nursing Improvision Theory (NIT) defines nursing improvision as competent and ethically founded, situation-responsive modification or creation of nursing action when standard protocol is insufficient, unavailable or misaligned with immediate patient needs. This definition is based on clinical judgment theory, adaptive expertise, and resilience science (Benner et al., 2010; Hollnagel et al., 2015; Tanner, 2006). Theory construction starts by identifying the primary constructs and functional relationships between them. The first construct is Situational Variability, and refers to the extent of unpredictability, fluctuation of resources, instability of the patient, disruption of work flow, or uncertainty of information that is part of a care context. Complexity literature shows that the variability is not at all uncommon but is part of the intrinsic nature of healthcare systems (Plsek & Greenhalgh, 2001). Situational variability is the major triggering condition for improvised nursing action.

The second construct is the Adaptive Nursing Expertise which is defined as the integration of experiential knowledge, pattern recognition, flexible reasoning and skill fluency for context-specific adjusting. This is an extension of the novice to expert and adaptive expertise models (Benner et al., 2010; Hatano & Inagaki, 1986). Adaptive expertise moderates the relationship between variability and paralysis, an unsafe deviation, and skillful improvision. The third construct is Clinical Judgment-in-Action, which is the real-time noticing-- interpreting-- responding-- reflecting cycle (Tanner, 2006). Within the framework of NIT, or nested in the cognitive world of clinical judgment is the cognitive-operational engine class of function that is the transformation of variability into assessed need and candidate response options. Improvisation is encountered when judgment realizes that protocolized action cannot adequately address the current condition.

The fourth construct is Creative Resource Reconfiguration that refers to the recombination, substitution, sequencing change, or method adaptation through available tools, knowledge, and relationships. This is supported by innovation and workaround research as a common frontline behavior (Tucker & Edmondson, 2003; Bhatti et al., 2017). This is the blueprint behavior of improvisation. The fifth construct is Ethical-Regulatory Framing, which limits the improvisation within professional accountability, patient-centered intent, proportionality of risk, and transparency (International Council of Nurses, 2021; Reason, 2000). This construct distinguishes between the legitimate improvision and the negligent deviation. The sixth construct is Reflective Evaluation and learning, which is defined as post-action appraisal, documentation, peer discussion, and organizational learning integration (Schön, 1983; Weick and Sutcliffe, 2015). This transforms acts of improvisations into knowledge assets and not isolated events.

From these constructs the theory moves on to bring forward the relational propositions. To start, when there is more situational variability there is more of a chance that nursing action will be improvised but only if there is adaptive expertise and clinical judgment capacity

(Plsek and Greenhalgh, 2001 and Benner et al., 2010). Second, adaptive nursing expertise is a positive predictor for safe and effective improvision and low adaptive expertise is a risk factor for unsafe deviation (Hatano & Inagaki, 1986; Reason, 2000). Third, ethical regulatory framing moderates the outcomes of improvised action to the extent that when the ethical grounding is strong, the patient safety is aligned (International Council of Nurses, 2021). Fourth, organizational psychological safety enhances reflection and learning that enhance the likelihood that improvised practices have a chance to turn into system improvements (Weick & Sutcliffe, 2015; Braithwaite et al., 2017). Fifth, repeated and reflective evaluation enhances adaptive expertise creating a feedback loop enhancing future improvision quality (Schön, 1983). Together these propositions establish the proposition that nursing improvision is not the result of random deviation of nursing but is a structured process of adaptive response which is activated under pre-defined conditions regulated by competence and ethics.

Structural Framework, Process Model, and Theoretical Assumptions

The Nursing Improvement Theory is organised in the way of a context - capability - action - evaluation process model. It works on the level of practices but is affected by organizational and education levels. The process starts with contextual disruption/variability, goes through capability filters (adaptive expertise and judgment), leads to the improvised action (creative reconfiguration of), and ends with reflective evaluation and system learning. This structure is aligned with both the models of resilience and naturalistic decision making and is grounded within nursing epistemology (Klein, 2015; Hollnagel et al., 2015).

Phase one involves Context Recognition. Nurses feel that there is disequilibrium between standard protocol and situational demand. This perception is based on situational awareness and recognition of cues, which are both emphasized in clinical judgment literature (Tanner, 2006). Without proper recognition, there is either no need for improvision, or it is directed in the wrong place. Phase two is the Phase of Judgment Framing. Interpretation of the situation, risk assessment, clarification of patient-centered goals, and an assessment of whether deviation is warranted falls to the nurse. This phase brings together the ethical and regulatory framing and the professional standards (International Council of Nurses, 2021). And phase three is Adaptive Design and Action. The nurse develops and applies an adaptation or innovation based on a given set of resources. This is where the creative reconstruction of resources takes place. Naturalistic decision research suggests that this step is often quick and experience driven (Klein, 2015). The fourth phase is Outcome Monitoring. Instant patient response and system effects are seen. Resilience literature emphasizes the important role of continuous feedback monitoring during the adaptive action (Hollnagel et al., 2015). Long-term memory phase five is Reflective Integration. The nurse describes, reflects, discusses, and adds learning to team or system channels. Reflection-in-action and reflection-on-action theories are in favor of this stage as central to the professional growth (Schön, 1983).

The theory is based on a number of explicit assumptions. First of all, healthcare environments are inherently variable and cannot be governed completely by fixed protocols (Plsek & Greenhalgh, 2001). Second, nurses have and can develop adaptive expertise outside of procedural competence (Benner et al., 2010). Third, there are instances where ethically-based deviation is safer than strict adherence to rules (Reason, 2000). Fourth, the adaptive acts are transformed into resilience in learning-oriented organizations (Braithwaite et al., 2017). Fifth, improvision quality can be trained with the help of simulation, reflective practice, and complexity exposure (Benner et al., 2010).

The theoretical boundaries are also defined. NIT is not an excuse for taking convenience shortcuts, reckless deviation, and improvisation by substituting one's competence with another. It applies only in a situation where there exists a co-existence of professional capability, ethical intent and situational necessity. It is a mid range practice theory, designed

to be used to guide the practice of education, design of simulations, framing of policies and empirical testing rather than as a substitute for grand nursing theories (Meleis, 2018).

Operationalization and Empirical Testability of Nursing Improvision Theory

For a nursing theory to be of scientific use, it has to be operationalizable and testable. Mid-range theory necessitates observable items, observable indicators and propositions that are falsifiable (Meleis, 2018). Nursing Improvement Theory may be investigated empirically through the use of mixed methods designs. One way to operationalize situation variability might be through indices of environmental complexity, measurements of workload variation and resource availability scales. Adaptive nursing expertise can be measured by experience level, performance in a simulation, adaptive reasoning measurements and supervisor rating (Benner et al., 2010).

Clinical judgment-in-action can be assessed with validated clinical judgment rubrics and clinical judgment scenarios and tools (Tanner, 2006). Creative resource reconfiguration can be found through ethnographic studies of work flows and critical incident technique interviews (Allen, 2014). Ethical-regulatory framing can be quantified by using ethical climate scales and decision justification audits (International Council of Nurses, 2021). Reflective integration can be determined by reporting frequency, participation in debrief, and documentation of learning systems (Weick & Sutcliffe, 2015).

Conclusion

This literature-based paper sought to build a structured Nursing Improvision Theory (NIT) based on available literature in the field of nursing, safety, decision and complexity scholarship. The review has shown that improvised nursing action is not marginal to practice but is part of the realities of everyday practice in settings characterised by uncertainty, variability and constraint in the delivery of care. Historically across disciplines of nursing research, clinical judgment theory, adaptive expertise research, resilience engineering and organizational learning literature, one or two patterns emerges that are consistent: Nurses engage from time to time in contextually sensitive, ethically furthered, competence-driven deviations or modifications of standard procedures to maintain the outcome of patient-centered care. What has been lacking is a coherent theoretical structure in which to name, bound, explain and guide this adaptive behavior.

The theory proposed aims at positioning nursing improversion as a disciplined adaptive process rather than passing and formulating a workaround. It identifies core constructs, i.e. situational variability, adaptive nursing expertise, clinical judgment-in-action, creative reconfiguration of resources, ethical-regulatory framing and reflective evaluation, and specifies relational propositions that link the context, capability, action and learning. By doing so, the theory overcomes a long-standing tension between protocol adherence and situation responsiveness that are repositioned as complementary instead of opposing dimensions of professional nursing practice.

Importantly, the theory makes boundary conditions. The improvisation is not being equated with a shortcut, a lack of care and convenience-driven deviation. It has been defined as Competence-based, ethically justified, proportionate, transparent, and reflectively evaluated action. This distinction is important for regulatory acceptance and educational integration, as well as safety alignment. The theory is also empirical testable with measurable constructs and observable behavior that qualifies it as a mid-range theory in nursing suitable for validation and refinement.

The ramifications are huge. For practice, the theory justifies talented adaptive action as it strengthens ethical responsibility. In the case of education, it advocates for educational training in the use of adaptive expertise, using simulation to expose us to complexity, and thinking by reflection. For leadership and policy, it focuses on the importance of psychologically safe, learning-oriented organisations that surface and assess adaptive

measures on the front lines instead of quelling them. For research purposes it opens up a new field of measurement, outcome research, and designing intervention.

In modern healthcare systems characterized by growing complexity and unevenness of resources, the level of effectiveness of the nurse clearly depends not only on what is standardized, but also on what is skilfully adapted. A formal theory of nursing improvision makes that adaptive dimension visible and teachable and governable.

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