

Intensive Care Unit Patients in the Post-Anesthetic Recovery Room:
A Case Study Exploring how Registered Nurses Manage Change

by

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Abstract

Health care in the acute setting is in a constant state of change with evolving technology, higher acuity, and changing patient care models. In the midsize hospital in this study there was a practice change which involved the Recovery Room nurses caring for Intensive Care Unit (ICU) overflow patients. The purpose of this research was to explore the experiences of the Recovery Room nurses during this practice change.

Six Recovery Room nurses from this mid-sized hospital participated in this study. Participants were interviewed using a semi-structured format with open-ended questions to guide the conversation. Interviews lasted 25 to 35 minutes, were digitally recorded, transcribed verbatim by a transcriptionist, and then checked for accuracy.

Interpretive Description was used to guide the data analysis. The first three transcripts were read independently by co-investigators who then met to construct an initial coding framework. This framework was used to code the remaining interviews with constant comparative analysis to ensure accuracy and integrity of the codes. The coding framework was then reviewed by the remaining committee members to further enhance coding integrity. The coding framework was continually refined throughout the study to strive for accuracy.

Three main themes were constructed from the data: the Expert Mind-set, Specialty Practice and Unit Culture. Expert mind-set was further broken down into sub-themes, Knowing but not Doing and Dual Focus/Dual Duty. Specialty Practice was broken down into sub-themes Doing but not Knowing and Contextual Supports. Finally, Unit Culture was broken down into Identity and Relationships.

These findings lead to a more in-depth discussion of the dilemma of not being able to deliver a standard of care, i.e. the concept of knowing but not doing, and the dilemma of generalist versus specialist approach to critical care, i.e. the concept of doing but not knowing.

The results of this study have multifaceted implications which include the use of a change model when implementing practice change; developing relationships to support practice change; valuing a self-directed learning culture; and the importance of having practice standards and resources available to support practice change.

Preface

This study was completed as a requirement for completion of my Degree in Master of Nursing. All data collection was completed by Crystal White with guidance from committee members. Analysis of the data was completed collaboratively with my Committee Advisor, Barb Pesut. Barb Pesut is listed as the principal investigator as required by UBC Okanagan Research Ethics Board.

The writing of this research was done in collaboration with Barb Pesut. All writing was reviewed by all of the committee members, Barb Pesut, Kathy Rush and Nancy Serwo. UBC Okanagan Research Ethics, reference number H10-00956 and Interior Health Ethics, reference number 2010-029 approval were obtained prior to beginning this study.

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I thank the participants of my study who were willing to give me their time and tell their story. Your willingness to share has allowed me to better understand your experience. I hope that my words accurately reflect the stories you shared.

Finally, I would like to thank my colleagues Sheila and Mary. Shelia, your sense of humour and great story telling often made me forget that I was working. Mary, you have been my biggest cheerleader and often had more faith in me than I did myself. When I was really struggling to continue it was often the thought of disappointing you that kept me going. Ladies, I miss the Thai food and the great conversations.

Dedication

I would like to dedicate this work to the boys in my life, my husband Todd and my son Kael. Todd has supported my work throughout this journey and has often brought more than fifty percent to the table to ensure that Kael always received one hundred percent. This work would not have been possible without such a wonderful partner and friend.

Introduction

The increasing acuity and complexity of patients found in acute care contribute to the ever-changing environment of health care. The healthcare delivery system is in a constant state of change due to advancing technology, new patient care models, and efforts to improve efficiency and meet increased demands. This study focused on a change in patient care practice in the Post-Anesthetic Recovery Room (PARR) of a 350 bed hospital in western Canada. A shortage of beds and nurses in the Intensive Care Unit (ICU) of this mid-sized hospital has resulted in critically ill patients being kept in the PARR overnight as “overflow patients”. These patients may be patients who would normally go directly from the OR to the ICU, or go from the OR to the PARR for a short stay prior to being transferred to the ICU, or they may be a patient being moved from the ICU to the PARR to allow the ICU to admit a more unstable patient to the ICU. When possible, nurses from the ICU are brought in, but when this is not possible the PARR nurses provide the care. This care includes skills that may be unfamiliar to the PARR nurses such as maintaining hemodynamic stability through the titration of vasoactive medication infusions; following established protocols for sedation, electrolyte replacement, and insulin infusion; caring for ventilated patients following ventilation weaning protocols; and responding to unexpected findings for a wide variety of both surgical and medical conditions.

The problem that this research addressed is the nurses’ concerns about their ability to provide adequate care given the complexity of ICU patients and the potential impact this could have on patient care. These concerns had been raised by the PARR nurses through casual conversation, staff meeting discussions, and initiation of Professional Responsibility Forms (PRFs). These concerns may in turn influence nurses’ job satisfaction. This study explored these practice changes as experienced by the nurses working in the PARR to better understand and address the concerns being expressed.

Definitions

Post Anesthetic Recovery Room (PARR): a hospital unit which is equipped by specially trained staff and apparatus for meeting postoperative emergencies and in which surgical patients are kept during the immediate postoperative period for care and recovery from anesthesia.

(Merriam-Webster's Medical Dictionary, 2002). PARRs vary in the acuity level of patients that they accept. The PARR under discussion in this study does not typically care for individuals who would be deemed to be an "ICU" patient for an extended period. (May also be referred to as a Recovery Room or a Post-Anesthetic Care Unit [PACU]).

Intensive Care Unit (ICU): A specialized section of a hospital containing the equipment, medical and nursing staff, and monitoring devices necessary to provide intensive care (The American Heritage® Stedman's Medical Dictionary, 2002).

Intensive Care: Continuous and closely monitored health care that is provided to critically ill patients (The American Heritage® Dictionary of the English Language, 2009).

Practice Change: Practice refers to the nursing care provided to address patient problems in a particular setting. A change in practice refers to a difference in the nursing care provided or the types of patient problems being seen in a particular setting. In this study the practice change refers to an increase in the complexity of patient problems found in this PARR such as maintaining hemodynamic stability through the titration of vasoactive medication infusions; following established protocols for sedation, electrolyte replacement, and insulin infusion; caring for ventilated patients with advanced airways such as endo-tracheal tubes and tracheostomies; following ventilation weaning protocols; and responding to unexpected findings for a wide variety of both surgical and medical conditions This study will explore retrospectively the change in practice of caring for critically ill patients in the PARR as overflow patients when the ICU is full. The period under study was January 2009 – January 2010.

Assumptions

This study is based on an assumption that the nurse's experience is a fundamental part of quality patient care. It is my belief that the job satisfaction experienced by the nurses influences retention and the quality of patient care. Further, I believe that because of nurses' close proximity to direct patient care they have intimate knowledge of important factors related to practice changes and their potential impact on patient care. It is because of this belief that I have chosen to address this problem through their experiences.

I am also making the assumption that the exploration of a single, in depth case study in a particular context, may not provide knowledge that is generalizable in the traditional sense; however, it may yield transferable knowledge that could be beneficial for supporting quality patient care under similar situations.

Background

An important background to this study is a general understanding of who the nurses working in the PARR are, what skills they are being asked to maintain, how work expectations have changed, and how the physical location of the PARR affect these changes. I will attempt to describe the landscape on which these practice changes are being played out at this mid-sized hospital.

Who Works in the PARR

The PARR being studied is a 15 bed unit staffed with Registered Nurses (RNs) from 0700-0200 seven days a week; two RNs provided on-call coverage from 0200-0700 at the time of the study. Traditionally, all of the RNs came from a critical care background; many had worked in the ICU of the same hospital. Recently, the unit changed its hiring practices due to the local nursing shortage, reflecting that being experienced worldwide. Presently, some PARR

nurses have taken a critical care course but have not worked in an ICU setting, while others were hired who do not have a critical care course or critical care experience.

The majority of the PARR nurses who have worked in the ICU have not worked in that setting for many years. There are a large proportion of the PARR nurses who are planning their retirement within the next five years. This group of nurses, in particular, voiced concerns about the change in practice. Interestingly, the nurses who had recently completed a critical care course expressed concerns about `losing knowledge` because of the infrequency of caring for a critical care patient in this setting. The common denominator between these groups of nurses was a concern over acquiring and or maintaining a set of competencies related to caring for ICU patients.

High Risk – Low Frequency Procedures

The frequency of overflow critical care patients being cared for in the PARR is sporadic and the care is complicated. The type of overflow patient varies according to the needs and abilities of the units involved. For example, a critically ill post operative patient may be transferred to the ICU while a more stable medical patient is transferred from ICU to PARR as an overflow patient. The rationale for this type of decision is based on the unstable patient being in the area with more resources, such as a higher number of nurses in the unit, a Respiratory Therapist, an Intensivist Physician available 24 hours a day and the equipment needed to care for complex ICU patients. This variety of patient type means that the PARR nurses require knowledge about a greater variety of disease processes and patient care modalities than they would encounter if caring strictly for postoperative surgical patients.

Work Expectations/Workload

The schedule at the time of this study was set up so that the evening nurses who worked 1800-0200 covered the on-call from 0200-0600 and the nurses who worked 0700-1500 covered 0600-0700. If there was an ICU overflow patient, the evening nurses worked from

1800-0600, the extra four hours were mandatory overtime. Since the schedule did not staff the unit overnight, nurses worked an extended shift as needed. This may be viewed unfavourably by senior nurses who were not interested in working more than their scheduled eight hour shifts.

There were plans to change the rotation so that PARR nurses would be scheduled for 24 hour coverage with rotating day, evening, and night shifts. The nurses would be expected to float to critical care areas to assist with patient care if there were no patients in the PARR. This scenario would remove the necessity of extended shifts but would result in the nurses working in unfamiliar areas with unfamiliar patient populations. There has been much anxiety expressed about this impending additional change of practice.

Physical Environment

The physical layout of the PARR suggests that it may be the perfect place for overflow ICU patients; it has cardiac monitors and emergency equipment and is staffed by nurses who know how to use both. This study explored whether the physical location of PARR contributed to the experience of the recovery room nurses when caring for ICU overflow patients. This unit is located in a separate building from the ICU but is connected by a hallway.

During the evening and night there were usually two to three nurses working in the PARR, whereas in the ICU there were 12 to 14 nurses who worked in collaboration with two Registered Respiratory Therapists to care for their critically ill patients. Many of the procedures and protocols ordered for ICU patients required supplies not stocked in PARR, which resulted in someone having to make multiple trips to the ICU.

Purpose of the Research

This research explored this practice change of caring for ICU patients in the PARR as experienced by the PARR nurses in a mid-sized western Canadian hospital. The purpose of this research was to develop a better understanding of how the Recovery Room nurses experienced

and managed the practice change of caring for complex surgical and medical ICU patients in the PARR. The objectives of this research project were the following:

1. To describe the nature of the practice changes that result from ICU patients being cared for in PARR as experienced by the PARR nurses.
2. To explore the experiences of the PARR nurses as a result of this practice change.
3. To understand the strategies the PARR nurses use to manage this change in practice.

Literature Review

Important literature that informed this study includes the nature of nursing in the PARR, change theory and learning theory. I examined the literature to gain a better understanding of the nursing practice within PARRs outside of the study unit and attempted to determine if the changes being experienced in the study unit were unique. Nurses working in PARR primarily define themselves as critical care nurses; this label is supported by the literature (Lindsay, 1999; Odem-Forren, 2003); yet, a critical care course has not been a prerequisite to working in this unit until recently. The PARR nurses in this hospital use the standards of the American Society of Peri-Anesthesia Nurses (ASPAN) to guide their practice but their competencies are aligned with the College of Registered Nurses of British Columbia (CRNBC) standards. The ASPAN standards state that the PARR is a critical care area and the nurses should meet critical care competencies. ASPAN in collaboration with the American Association of Critical-Care Nurses (AACN) and the American Society of Anesthesiologists (ASA) developed a position statement on ICU overflow patients in PARR (American Society of PeriAnesthesia Nurses, 1999). This statement made it clear that the practice of ICU overflow patients being cared for by post anesthetic nurses in PARR is supported by the society. This statement also stressed the necessity for appropriate staffing levels and that the nurses must be competent to care for these critically ill patients. The statement does not address how these Recovery Room nurses are to acquire or maintain this competence. Schmalenberg et al. (2008) described competence as the integration of six domains: ability to autonomously make clinical decisions, ability to prioritize and multi-task, interpersonal competence, technical skill competence, knowledge competence, and maintenance of quality patient outcomes.

While the PARR in this study uses ASPAN to guide practice, the unit competencies follow the standards of the CRNBC. These competencies do not reflect the ASPAN critical care competencies. There are some similarities such as cardiac monitoring, arrhythmia interpretation

and treatment, airway management, and endotracheal tube removal; but it does not include ongoing care of a patient on a ventilator or managing a hemodynamically unstable patient on vasoactive medication infusions. Therefore, it is important to note that though ASPAN standards are used to guide the practice in this PARR, these standards are not specifically reflected in their competency document.

The majority of nurses in this PARR had come from the Intensive Care Unit (ICU) so they have had critical care training. Continual changes in technology and changes in treatment modalities often resulted in a concern that their knowledge was obsolete within a short period of leaving ICU. This diminishing lifespan of knowledge along with the low frequency of some highly technical skills results in difficulty in maintaining competency. Goldsorthy, Graham, Bornais and Pfaff (2008, October) presented on this topic at the annual Dynamics of Critical Care Conference in Montreal; they discussed the challenge of maintaining these low frequency advanced skills in the ICU. One would expect that it would be even more challenging in the PARR where frequency would be significantly lower.

Articles addressing the issues faced by PARR nurses caring for ICU overflow patients date back to the 1990s (Lindsay, 1999; Odem-Forren, 2003). Lindsay (1999) described a similar practice change which occurred in a hospital in the eastern United States, but only surgical ICU patients were 'boarded' in the PARR. In her article, she provided a personal account of the issues that arose in her unit during this transition such as communication between the ICU and the PARR regarding patient flow and appropriateness of patient selection for overnight in PARR, determination of physician coverage for overnight patients, and maintenance of low frequency skills for the nurses working in the PARR. Lindsay provided guidelines to assist in making a smooth transition but no information was provided concerning how these guidelines were established or whether the transition was successful. The guidelines focused on which physician service would be writing orders on the patient, what documentation would be used,

and what staffing levels were required (Lindsay, 1999). Lindsay acknowledged that it was challenging to keep staff feeling competent with low-frequency skills.

Odem-Forren (2003) discusses the trend of ICU overflow patients being cared for in the PARR. She identifies a need to address issues such as maintaining appropriate staffing levels to ensure the flow of the surgical schedule, and providing the PARR nurses with necessary education and resources to competently care for the ICU patient. She does not discuss the appropriateness of having PARR nurses care for the ICU overflow patient but rather focuses on the collaborative approach required to ensure it is done safely.

Callaghan et al (2005) at a Cambridge hospital in the United Kingdom carried out a study between 1998 and 2002 involving patients who were to undergo elective open aortic surgery; patients who met specific criteria were cared for in the PARR overnight. These patients had to be hemodynamically stable and not ventilated and could not stay in PARR longer than 24 hours post-operatively. This study showed no change in patient outcomes and was seen as a way to address the increasing demands on the ICU beds. This study mentioned the importance of nursing expertise but did not discuss any supplemental education being provided to the nurses working in this unit or the nurses' experience with this change in practice.

The use of a simulated review of high-risk, low-frequency skills is frequently used in critical care areas. Morgan (2007) described an annual simulated review for PARR nurses at a facility in Daytona, Florida, with claims of increased nurse satisfaction and comfort with infrequent skills as determined through evaluation forms. Simulation of infrequent skills for review on a regular basis may address this nursing competency issue; the challenge would be to include the great variety of skills required in the PARR and ICU.

The value of educational support and clinical competence is supported in a study that examined the essentials of a satisfying and productive work environment from the perspective of staff nurses (Kramer & Schmalenberg, 2008). This study listed working with clinically

competent peers and support for education as two out of the top eight essentials to job satisfaction. Utriainen and Kyngas (2009) conducted a literature review looking at nurses' job satisfaction. This review of 21 studies uncovered two recurring themes that increased job satisfaction, positive interpersonal relationships between nurses and quality patient care.

The literature highlights the importance of a transitional plan during a change process (Curran-Smith & Best, 2004; Johnson, 1998; Knight, 1998; Lewin, 1951); this transitional change process is particularly relevant with a practice change of this nature. Ideally a process will be in place to support nurses' educational needs when a practice change is implemented. If nurses feel that they cannot competently care for the patients in their unit, they may leave that area resulting in even greater nurse shortages – worsening the problem.

Two theoretical frameworks support a better understanding of the experiences of the PARR nurses in this study: change and learning theory.

Change Theory

Change and healthcare have always gone hand and hand, with new ideas, technologies, knowledge, and approaches being adopted into practice then dismissed for something believed to be better or more efficient. New approaches to patient care are tried, pushing nurses to attain new skills and knowledge to care for high acuity patients with decreasing resources while they seek to maintain relationships with their patients and families. Change is part of everyday life in healthcare because we are continuously trying to improve upon the art and science of caring within the confines of limited resources. The change examined in this study involved bringing the technology and knowledge of the ICU into the PARR in response to the limited resource of ICU beds.

Kurt Lewin's (1951) change theory is often cited as the foundational model of change. Lewin identified three stages of planned change which included the 'unfreeze', 'transition' and 'refreeze' stages. There are many who believe in the merits of this theoretical approach and I

believe that it provides some understanding around the implementation of change. However, some of the constant changes found in the healthcare delivery system appear to come without careful thought or deliberation. Johnson (1998) wrote about the importance of staff nurses participating in changes to patient care models and listed three essential components to change: comprehensibility, manageability, and meaningfulness. She stated that there is a decrease in resistance to change if the nurses are informed of what will be happening, why it is happening, and when it will be happening. The nurses must believe they have the resources to manage the change and they are able to take ownership of the change. The nurses in the PARR were not part of the practice change until the day there were no beds in the ICU for a post operative patient who required critical care. This reflected a reactionary response rather than a planned change.

Curran-Smith and Best (2004) also discussed the importance of clear communication, opportunities for staff discussion, and adequate resources when attempting to implement a change in practice. The nurses must appreciate the benefit of the change if they are going to adopt changes to their practice without resistance. If nurses feel that a change is being pushed on them without regard for how this change will affect them and their patient care their reaction will probably be to push back.

Knight (1998) wrote about the grief response to change for nursing lecturers in England during a time of major curriculum and organizational upheaval. He describes a loss of control, alienation, and a cultural disruption. Knight also emphasizes the importance of a change strategy which includes clear communication to avoid confusion and stress, group work to enhance awareness, and provision of resources and support for the change.

Learning Theory

Learning theory provides an understanding of the significance of education for preparing nurses for the types of changes described in this study. The College of Registered Nurses of

British Columbia (CRNBC) supports continuing education as an essential part of all nursing practice. Annual continuing education is a licensing requirement of all Registered Nurses by CRNBC. This education is self-reported with the rare possibility of audit. There is a belief by the college that it is the nurses' professional responsibility to ensure that her/his knowledge is current and that her/his practice meets CRNBC standards. "The Canadian Nurses Association (CNA) believes that to practice safely and competently, nurses must acquire, maintain and continuously enhance skills, knowledge, attitude and judgement in their area of practice" (CNA, 2001, p. 1). However, the boundaries between continuing education as a part of regular practice and acquiring new knowledge in relation to a nursing speciality are not always clear. Who is responsible for the education when there is an employer mandated change that constitutes specialty knowledge? Another reason that continuing education is valued is the increasing acuity of patients and the complexity of technology present in healthcare. There are many changes and advances in technology being used at the bedside that require nurses to continually upgrade their skills if they want to work in acute care.

Specialty certifications recognized by associations such as the CNA attempt to address the need for advanced education requirements in some specialty nursing areas. These certifications require that a specific number of continuing education hours be maintained. It is important to note that the certification exam for PARR nurses is different than the Critical Care certification exam. CNA recognises these areas as distinct with their own body of specialty knowledge. Although there is overlap between the two areas, certification is distinct.

Many American states have removed mandatory education from their licensing requirements because it is often seen as costly to monitor and ineffective (Carpenito, 1991). Carpenito states that "if practitioners are not self-directed in their desire to keep up to date, courses of continuing education can become mere time-serving exercises" (p. 29). This is to say that attendance in a continuing education course does not ensure learning has occurred. The real issue of ensuring nurses stay current with their knowledge and skills is determined by 'their'

motivation to do so. Carpenito states that 100 different studies in the USA tried to determine whether mandatory continuing education improved nursing practice; none were able to confirm improved practice. The expense of tracking education hours, without proven practice improvements, makes mandatory continuing education a questionable endeavour.

Lifelong Learning versus Continuing Education

It is first necessary to clarify the difference between the terms lifelong learning and continuing education. Lifelong learning involves acquiring knowledge, either proactively or reactively, throughout the lifespan (Jarvis, 2005). An example of proactive learning would be the nurse who identifies a learning need and then seeks out the necessary resources to meet that need. Reactive learning may take the form of reflection on a practice scenario to try and learn from that experience. Murphy (2006) discussed the concepts of intrinsic and extrinsic motivation for learning. Intrinsic motivation refers to personal or internal factors such as curiosity, pride, drive, sense of recognition, and desire for meaningful interactions to name a few. Extrinsic motivation comes from external factors and may include material rewards, positive feedback, and recognition from management or peers.

Continuing education, on the other hand, involves the provision of learning opportunities (Jarvis, 2005). Often the education material is provided by an educator or manager through in-services, workshops, self-study modules, bulletin boards, and on-line programs. The content of the continuing education is often determined by someone other than the participants. As stated above, simply requiring continuing education does not guarantee that learning has occurred. In order to motivate learning you must create a learning culture where learning is valued and sought after. In the context of this study, the question arises of whether specialty education should be a function of life-long learning or continuing education.

A Learning Culture

Fostering a culture of learning is key to learning theory. In accordance with adult learning theory, learning must be self-directed with individuals developing their own learning needs, learning objectives, learning strategies and evaluation (Knowles, 1975). O'Shea (2003) concluded that self-directed learning in nursing leads to increased confidence, autonomy, motivation and preparation for life-long learning. O'Shea goes on to state that not everyone is ready for self-directed learning but that the goal of educators should be to facilitate the learners' growth towards self-directed lifelong learning.

Gopee (2002) showed a direct link between lifelong learning and enhancement of patient care. Gopee identified three key areas that affect lifelong learning: organizational, socio-political and individual. Organizational factors such as education funding, in-house education, regular evaluation, career opportunities, and managerial support all significantly influence the learning culture of a unit. These factors reflect the organization's value of education which will influence the individuals' value of education. Socio-political factors include the presence of multidisciplinary students in the workplace, the use of peer reviews, attitudes of social groups working in the unit, and society's values regarding learning (Gopee, 2005). Individual factors refer to personal attributes such as an inquisitive mind, personal value of lifelong learning, and ability to adhere to one's value system.

Creating a learning environment which facilitates self-directed learning and ultimately, lifelong learning is a complex process. Any cultural shift in a work environment requires a full understanding of factors that created the existing culture and a plan on how to facilitate change. Inclusion of staff in understanding the current culture allows them to become engaged in the process of change (O'Shea, 2003).

The literature supports the idea of implementing change using a change model to support the process. While there are a variety of change models available, they all share the

common principles of good communication, involvement of all stakeholders, and ensuring adequate resources are available to support the change. There is also support for creating a learning culture where self-directed learning is valued and supported. All real and perceived obstacles to the change must be addressed to ensure engagement in the change process.

Method

The design for this study was a qualitative case study approach using interpretive description as developed by Thorne et al., (1997, 2008). The use of the term case study is “not a methodological choice but a choice of what is to be studied” (Stake, 2005, p. 443); in this case it was intended to denote the uniqueness of a PARR in a local mid-sized hospital in western Canada, during a specific timeframe. Stake uses the term ‘intrinsic case study’ when the focus of study is to better understand a particular case. The focus of this study was bounded to one PARR during a one year period during which a practice change occurred. The knowledge gained was not generalizable because it was specific to this particular unit during a particular time, but the knowledge gained may be transferable to similar contexts.

Qualitative semi-structured interviews were used to gain an in-depth understanding of nurses’ experiences and strategies for managing the practice change as described by the listed objectives. Interpretive Description provided the framework for analysis.

Interpretive Description Research is embedded at the practice level. It is not merely about providing a description of an experience but goes on to ask “the ‘so what’ that drives all applied disciplines” (Thorne, 2008, p. 33). Interpretive Description attempts to locate clinical research in clinical practice rather than in the theoretical traditions of the social sciences (Thorne, 2008). The tension between a purely theoretical approach and a practical discipline was the driving force behind the development of Interpretive Description. This qualitative approach provided a nursing specific approach to the issues identified by the PARR nurses during this practice change.

Sampling and Recruitment

Purposive sampling was planned to gain data from nurses with a variety of experience levels. However, the sampling method ended up being convenience sampling because of

challenges in recruiting nurses to take part in the study. To be included nurses had to hold a permanent part-time or full-time position and have cared for an ICU overflow patient between January 2009 and December 2009. Nurses were excluded if they were currently working in ICU.

Participants were recruited in the following manner. An information letter was sent to the manager, the Patient Care Coordinator (PCC), and directly to the nurses (see appendix A). A contact email was supplied for nurses who wished to participate in the study. Once individuals indicated that they were interested in participating I sent them a consent form and then contacted them regarding any questions they had. If they chose to participate, I set up an interview at a time and place which was convenient for them. Participation was completely voluntary. Confidentiality was ensured through elimination of all identifiers that could link data collected to a particular participant. All participants signed a letter of consent at the time of the interview (see appendix B).

I planned to interview six to ten participants. Thorne (2008) discussed the abstract quality of suggesting an arbitrary number requirement for a study. I had determined that my proposed sample would be approximately 33% of permanent staff with an effort to purposively select junior, intermediate, and senior staff. This would provide rich data to inform interpretations. There was an understanding that I would never reach data saturation since the variety of collectable data was infinite (Thorne, 2008). I understood that what I collected would simply represent the time-limited, contextual experience of the participants of my study.

Data Collection

Semi-structured Interviews were completed using an interview guide (see appendix D). To meet objective one of documenting the nature of the practice changes that resulted from ICU patients being cared for in PARR, I asked the participants to describe the complexity of an ICU overflow patient. I asked specifically what they felt constituted a complex patient. Objective two

was achieved through questions regarding perceived changes to required knowledge, skills, and abilities for the nurses to perform their job. Objective three was accessed by prompting nurses to discuss how they have managed these changes in practice. In addition nurses were asked to critique what they felt had supported their transition and what had hindered their success. All questions were open-ended to allow the participants to expand on details of their experience. The interview guide was piloted with a single participant and then revised for the remainder of the interviews. Interviews took place at a location of their choice but away from the PARR. Demographic information was gathered for each participant which included their number of years nursing, number of years working in the PARR, nursing experience background, and specialty education attained (see appendix E). Field notes were written after each interview.

Data Analysis

January 2009 to December 2009 provided the context for the study. All interviews were digitally recorded and then transcribed verbatim by a transcriptionist and checked for accuracy. B. Pesut, my committee chair and I independently completed an initial reading of the first three interviews and began to code major themes pulled from the transcriptions. We then met and constructed a coding framework.

This framework was used to code the remainder of the interview transcriptions. The codes identified were subject to constant comparative analysis to ensure accuracy of interpretation and understanding of relationships between codes. These codes were then organized into broader themes. Thoughts, observations, and reflections from my post interview notes were reviewed, looking for congruency with major themes and relationships pulled out of the transcripts.

The coding framework and themes were then reviewed by the remaining committee members, K. Rush and N. Serwo to support integrity of interpretations and relationships. The coding framework was continually refined throughout the study allowing the final interpretations

to be as accurate as possible. Constant challenging of the themes and patterns was necessary to confirm linkages. I constantly asked myself 'what am I seeing' and 'why am I seeing it' (Thorne, 2008). I went back to participants, not just for data checks but to discuss themes and patterns that had emerged. The results are only useful if they resonate with the nurses working in the practice setting. Interpretive Description is built upon 'reasonable logic' so results should not be a surprise to practitioners (Thorne, 2008).

I also searched for what I was not seeing. Data that did not confirm identified themes and patterns was explored. Discussions were held with committee members to explore differing ideas on how the data should be interpreted. The idea was to have meaningful discussions which included people who may not see the data as I did. The depth of the analysis depends on the scrutiny it has survived.

Interpretive Description is a "complex inductive reasoning process" (Thorne, 2008, p. 163). Thorne states:

Findings reflect an interpretative maneuver within which you consider what the pieces might mean, individually and in relation to one another, what various processes, structures, or schemes might illuminate about those relationships, and what order and sequence of presentation might most effectively lead the eventual reader toward a kind of knowing that was not possible prior to your study. (p. 163)

Part of the process of ensuring this entailed checking the results with participants to ensure that the findings were meaningful to their work. The goal of this process was to illuminate insight rather than develop theory. The focus from beginning to end was to address a practice issue as identified in the practice setting.

Credibility/Trustworthiness

Thorne (2008) identified evaluation criteria in an attempt to enhance the credibility of qualitative research. The criterion suggested by Thorne includes epistemological integrity, representative credibility, analytic logic, and interpretive authority. Epistemological integrity was

achieved by ensuring that the nurses' ways of knowing were consistently reflected through the research question, study design, sampling, data collection, data analysis, and findings presented in this study. Carper (1978) identified four patterns of knowing in nursing; empirical, esthetics, ethics, and personal in an attempt to capture the complexity of nurses' ways of knowing. Others, like Benner and Young, added to this idea through writings about tacit forms of knowing such as experience and intuition; and Chinn & Kramer later referred to knowing as a process of perceiving and understanding the world (Zander, 2007). The focus of the data collection was from the experience of the nurses working in the PARR during the period being studied.

Purposive sampling was planned to attain representative credibility. I had hoped to interview nurses with a variety of experience in PARR with and without critical care training and ICU experience. The criteria for participation eliminated nurses who had not cared for an ICU overflow patient during the defined timeframe. Every effort was made to ensure the participants fairly represented the PARR during this practice change. Challenges in recruitment resulted in the use of convenience sampling to ensure adequate numbers for the study. However, when reviewing all the 18-20 potential participants in this particular Recovery Room only two had less than five years experience as a nurse. The demographics of this study group do adequately represent the characteristics of this unit when considering experience both as a nurse and a Recovery Room nurse.

Quality was maintained throughout this study by ensuring participants were recruited based on pre-determined criteria with adequate assurances that participant confidentiality was respected. The quality of the data resulting from the interviews was dependent on the participants' belief that confidentiality would be maintained. Interviews took place at a time and location selected by the participant to ensure their convenience and comfort. Care was taken to ensure participants were participating voluntarily and did not feel coerced in any way.

Field notes provided a clear outline of the steps of the data analysis process. This helped to demonstrate the logical analysis of the data and allowed readers of the study to follow the sequence of decision-making and interpretation.

While insider research may have the advantage of doing research in a familiar setting with familiar processes there are limitations that must be acknowledged. In an attempt to maintain interpretive authority it was necessary to be aware of assumptions regarding the study topic, participants and unit culture (Asselin, 2003). I was vigilant in asking for clarification of data from participants and ensuring data was reviewed by co-researchers who do not work in the hospital setting. I used self-reflection in an attempt to identify assumptions and strive for objectivity through the research process.

Asselin (2003) also identified the importance of repeated emphasis on my role as researcher. While I did not work in the PARR, I was perceived as a clinical resource for critical care issues, it was important that the nurses were reminded throughout the study that I was in my role as researcher and not educator during this process. It was necessary to reassure the nurses that the information shared would not be used in any way other than to inform the study and that there would be no way to connect data collected with any particular participant.

All participants were asked to validate their responses to ensure the accuracy of data collected. Analysis of the data by multiple reviewers for coding assisted with identifying personal biases and assumptions. All data from interviews and field notes were reviewed by co-investigators who worked collaboratively to pull out major themes and relationships, which were recorded in a code book. The data and code book were reviewed by other committee members to ensure integrity of interpretations. Interpretations from data analysis were taken back to the participants to be checked for accuracy of themes and patterns. Themes and patterns that emerged from the data had to resonate as truthful for the participants. If there was disagreement around the data or analysis then this disagreement would become the focus of the discussion. The purpose of this approach was not to establish `new truths` but rather to

explore the commonality of a shared experience. The credibility and truthfulness of the results were reflected in the responses of the participants.

Positioning of Self (Ontology)

The lens through which I look is very much from the bedside. I am a nurse first, an educator second, and a researcher third. My interest in research begins and ends with the motivation to improve patient/family care and to support the nurses who provide that care. I am pragmatic in my belief that knowledge should be useful and my focus is on providing the best care that is economically reasonable. Although I work in a highly technical environment I believe good care can only be given if we remember that we are participating in human relationships.

I do ascribe to Barbara Carper's fundamental patterns of knowledge in nursing (1992). This is to say that while each interaction is unique to the participant, context, and time; it is also true that "patterns and themes do occur within subjective human experience" (Thorne, 2008, p.79). Nursing is messy and complicated and requires knowledge in the physical, emotional, psychological, relational, and social domains. Thorne, Reimer Kirkham, and MacDonald-Emes (1997) described nursing as a holistic, interpretive, relational practice discipline and I would agree with this description. The key to this approach is that similarities of experience are gathered allowing patterns to be identified while the uniqueness of experience is accepted. This is not about generalizing a theory to a greater population but rather deepening an understanding of our shared humanness (Thorne, 2008). For this study, although I was describing a unique context and time, there should be some transferability of that knowledge to practice situations that have similar changes occurring.

Ethical Considerations

Qualitative research, in general, requires a thoughtful approach to ensure the principles of ethical research are upheld. The Tri-Council Policy Statement (TCPS) outlines seven guiding principles aimed at ensuring respect for human dignity: free and informed consent, respect for

vulnerable persons, respect for privacy and confidentiality, respect for justice and inclusiveness, balancing harm and benefit, minimizing harm, and maximizing benefit (Tri-Council Policy Statement, 2009). I received approval for this study from the Ethics Board for the University of British Columbia, Okanagan and the Interior Health Authority.

My positioning as a nurse educator had a significant influence on the questions I asked, the responses of the participants, and my interpretation of the data collected. It was vital for me to be transparent in my positioning throughout the process. The purpose of the research had to be clear for myself as well as the participants; why was I asking the question and who would benefit from the results? I made every effort to balance the dual role of educator/researcher, insider/outsider. If an issue of competency had come to light during the interview I would have made a plan to address education needs outside of the study. The educational plan would have been developed in collaboration with the nurse involved once the interview had been completed. The nurse would be assured that the educational plan would not be part of the study data.

Free and Informed Consent

When asking participants to participate in this research, it was crucial that they understood my role as researcher and that the purpose of the research was transparent. I have worked as a staff nurse in the Recovery Room and I am presently one of the Critical Care Educators covering this unit. Brayboy & Deyhle (2000) wrote about the process of ensuring participants accept the different roles an insider researcher plays. They discussed the idea of openly identifying the various roles with participants. I believe this was similar for me; I discussed my role as an educator versus a researcher with participants so they could decide if they were able to separate the differing roles. It was essential that they could make this separation if they were going to be able to give free and informed consent.

If participants could not make this separation, there was a risk of participants feeling coerced into this study. Thorne (2008) identified coercion as one of the greatest risks of insider research. As an educator it may be perceived that I hold some power in the unit since this is a leadership position. Whether real or imaginary this perceived power could influence nurses to participate and it could influence the data they shared. It was necessary to openly discuss this possible perception so nurses believed their decision to participate, or not, would have no effect on our relationship or their standing in the unit.

The nurses' understanding of my role as researcher was also important so that their expectations were realistic. Asselin (2003) identified expectations of participants as being a potential pitfall for insider research. Just as I did not want nurses to participate because they felt coerced because of my educator role, I also did not want them to participate because they believed it would give them a connection to management in an attempt to effect change. Although, Brayboy & Deyhle (2000) stated that "all research, by its very nature, is political" (p.163), it was imperative that all perceptions of roles and expectations of research were discussed openly if consent was going to be free and informed.

Respect for Privacy and Confidentiality

The assurance of privacy and confidentiality was very challenging during this research project. The unit is fairly small with less than twenty regular nursing staff. Thorne (2008) suggested including multiple research sites or using vague descriptions to describe facilities to keep their identity confidential. Multiple research sites were considered but it was not feasible for this study. I felt that it is important to share the research with the participating unit, so it was challenging to maintain privacy and confidentiality with such a small group. Thorne emphasized that the research results must be written as perspectives rather than facts, this helped to avoid obvious connections between participants and data. Participants were asked through the consent process if quotes could be used anonymously in the dissemination of the results of this study.

It was necessary to establish relationships with the participants so that they felt they could trust me to maintain their privacy and confidentiality. Creswell (2007) discussed the importance of developing respectful and supportive relationships with participants. It was very important that the nurses did not feel that I was judging them or that I was going to report them to management if they disclosed what they perceived as negative information. There was no evaluative information gathered during this study. I felt that I already had a relationship with many of the nurses in this unit and I attempted to cultivate those relationships so that the nurses felt that they could be candid with me without fear of reprisal or embarrassment.

The description of the complexity of the patient being kept in the PARR overnight, as described by the participants, provided a clearer picture of the nurses' experience. The collection of demographic information, such as the education and practice experience of the participants helped to put the practice change into context for this particular unit.

All data gathered was aggregated when presented in the findings in such a way that no individual participant could be identified. No composite information was presented on the individuals involved.

Balancing Harm and Benefit

The issue of balancing harm and benefit made me ask the question - Who benefits from this research? There must be benefit for the nurses of the unit and the patients they care for if this research was to have meaning. Brayboy and Deyhle (2000) expressed concerns about participants being exploited for their own end. There were undeniable risks of loss of privacy and confidentiality, as discussed above; these risks were not to be taken to simply satisfy my Master's Program requirement. I believe that by developing a better understanding of how these nurses experienced this practice change I would be able to facilitate increased support for nurses as acuity continues to increase and practice continues to change.

There was also the potential to do harm to my relationship with the nurses working in the unit. There were decisions and changes that were initiated from administration which were completely out of my control. There have been many such changes in this unit; so there was a risk that a change from administration may be perceived as being linked to the research project. Brayboy & Deyhle (2000) discussed the perception of a political agenda blocking participation or limiting disclosure for fear of the true motive behind the process. This brings it back to the trust issues and relationship building. Fine, Weis, Weseen, & Wong (2000) stressed the importance of being transparent about who the research is for and where the power lies in the process.

Another consideration around the harm and benefit of research involved the quality of the research itself. There are distinct advantages and disadvantages to insider research that have been discussed by many writers. Some advantages include access to participants, previous knowledge of organization processes, and existence of relationships with participants (Asselin, 2003). Thorne (2008) discussed how access and background contextual information are advantages for the insider researcher. These advantages help increase the quality of the research data collected.

There are disadvantages to insider research that may decrease the quality of the data which may also affect the harm and benefit of the research. One of the disadvantages of insider research discussed by Asselin (2003) and Thorne (2008) is an assumption of an understanding of the culture when deeper probing would have enhanced data collection and analysis. Asselin suggested that the inside researcher assumes nothing about the phenomenon so data can be collected with 'fresh eyes'. I suggest that 'bracketing' of your assumptions is not only impossible but undesirable. This approach would negate the advantage of already having some understanding of the culture. Instead, I feel that outlining your assumptions and being explicit about your positioning will help to avoid the pitfall of taking information for granted without deeper exploration.

An ethical research project must ensure an ethical research process from the initial development of a question through to interpretations of data analysis and distribution of results. Ethics must be part of each step along the journey, rather than single step taken before the journey begins.

Findings

Description of Study Participants

Six Registered Nurses (RNs) participated in interviews held between November 3rd, 2010 and January 29th, 2011. Participation was open to all RNs working in the Recovery Room at this time including the Patient Care Coordinator (PCC). Licensed Practical Nurses (LPNs) were not included since they do not take over the primary care of patients in this area. An information letter inviting the nurses to participate was presented by the PCC at a staff meeting. There was very little response to the initial request so the PCC presented the letter at several subsequent staff meetings and posted the information letter on the bulletin board in the Recovery Room. The PCC directly contacted nurses who had been working in the Recovery Room at the time being studied but were no longer working in that area. All nurses who wished to participate were interviewed except for one who moved away before the interview could be completed. Demographics of the participants can be found in Table I.

Of the six participants, three had a Nursing Diploma, three had a Bachelor of Nursing Degree, one of which had completed a Master of Nursing Degree. All but one of the participants had more than 20 years experience in nursing with half of the participants had 11 or more years experience in the Recovery Room. Relevant to this study is that five of the six participants had worked in the Intensive Care Unit (ICU) previously, for a minimum of two years, but the experience of four of those five was at least ten years ago. Four of the participants had completed a specialty certification in Critical Care. All six participants worked in the Recovery Room during the time this change in practice occurred. Two of the six were no longer working in the Recovery Room but were still working at the same hospital.

Table 1: Demographic Characteristics of Study Participants

Characteristics	Participants (n)
Highest Level of Education RN Diploma or Associative Degree Bachelor's Degree in Nursing Other – Masters in Nursing	3 2 1
Specialty Education¹ Critical Care Post-Anesthetic Recovery Other None	4 2 2 2
Years of Experience in Nursing < 2 years 2 - 5 years 6 - 10 years 11 - 15 years 16 - 20 years > 20 years	0 0 1 0 0 5
Years of Experience in Post-Anesthetic Nursing < 2 years 2 - 5 years 6 - 10 years 11 - 15 years 16 - 20 years > 20 years	0 1 1 1 2 1
Worked in ICU (past or present) Yes No	5 1
Number of Years working in ICU < 2 years 2 - 5 years 6 - 10 years 11 - 15 years 16 - 20 years > 20 years	0 2 2 0 0 1
Number of years since working in an ICU ≤ 5 years 6 – 10 years 11 - 20 years > 20 years	1 0 3 1
Currently working in the Recovery Room Yes No	4 2

¹ Some participants had more than one specialty

Introduction to Findings

The findings from the participant interviews will be presented in this chapter. Three main themes were constructed from these interviews: the expert mind-set, specialty practice, and unit culture. These findings will be discussed in detail with quotes embedded to support and fill out the themes. Every effort has been made to ensure the anonymity of the participants so no names will be used. Instead I will refer to Participant A, B, C, D, E, and F. I will also comment on frequency of finding. For example if one finding was mentioned by most or all participants as opposed to one or two I will make this clear. This does not suggest that one finding is more significant than another. Assuming increased frequency of data indicates an increased significance is a potential pitfall in Interpretive Description (Thorne, 2008). Rather, the frequency of data will be outlined to help the reader understand more about the prevalence of the problems perceived.

The Expert Mind-set

All of the participants attempted to describe the feelings they experienced while caring for ICU overflow patients in the Recovery Room. The construction of the theme 'Expert Mind-set' attempted to capture the feelings and experiences described by the participants. The term mind-set is being used to describe both the participants' thought processes and subsequent emotions as they cared for ICU overflow patients. This major theme was further broken down into two sub-themes, Knowing but not Doing and Dual Focus/Dual Duty.

Knowing but Not Doing

Most of the participants described experiencing stress while caring for ICU overflow patients. They knew what they should be doing but felt incapable of doing it. Participants had many years of nursing experience, some of which had previously occurred in ICU, and spoke of what they envisioned as quality care for an ICU patient. However, they were often unable to provide that level of care because of circumstances beyond their control.

We do the best we can do in the situation and none of us feels that we're doing the best for the patient because we all know what the best is, we have worked there, and in an area where we know what to do (Participant B).

The distress participants felt was sometimes acute as indicated in the following quote by Participant F.

....it was very, very wearing, very upsetting that I was not able to give the optimum of care because that's how I was trained and that's how my nursing philosophy is, and it was like nobody was listening to us, to our concerns....I think with nursing you're there for your patients and I just feel that we can't give the best care to our patients because of the administration at this hospital.

With this participant the sense of distress was exacerbated by her belief that the administration could alleviate the situation but chose not to. Indeed, there was a sense among the participants that the administration and the nurses were at odds over what was considered quality patient care.

Participant C spoke of the gap between knowing high quality care based upon her experience working in ICU in the past and what she could currently provide in the Recovery Room. This nurse knew what she did not know. She was aware of the complexity of the care of an ICU patient but felt she no longer had the knowledge necessary to provide that care, resulting in a sense of distress. This sense of feeling overwhelmed was visible throughout this interview. The participant appeared anxious as she recalled her experience, her breathing became quite rapid and she flushed as she told her story. Part of her feeling of being unable to provide the desired level of care was related to her acknowledgement that she was unfamiliar with the current standards of ICU nursing as evident in the following statement:

...all of a sudden nine years in Recovery and I'm having to go back and deal with all this again, it was like I don't know if I can do this.

Participants repeatedly expressed distress concerning the gap between what they considered quality care to be and what they were able to provide their patients, a gap they felt was created by decisions outside of their control.

Dual Focus/Dual Duty

Another theme that was constructed from the interviews was the feeling of dual duty or dual focus needed to care for these patient populations. The term dual duty refers to the idea expressed by the participants that they were functioning as both a Recovery Room nurse and an ICU nurse at the same time. Many of the participants spoke of trying to provide the complex care an ICU patient required while continuing to recover patients coming out of the OR. This resulted in having to maintain a dual focus. Several of the participants spoke of the different goals for these patients, phase one recovery versus management of critical illness. The Recovery Room nurse assesses and cares for a patient during the unpredictable period of anesthetic recovery. Care includes taking frequent vital signs, ensuring adequate ventilation and increasing level of consciousness, monitoring the surgical site, and treating pain as the patient recovers full consciousness. In contrast, the ICU patient is often complex with multi-system patient problems. Care includes adhering to medications or therapies that have complex protocols.

It was not always necessarily the different nature of the task and goals but rather having to manage them concurrently. Many of the participants spoke of multiple focuses being required at any given time, including caring for ECT and cardioversion patients, ward patients who were overflow patients, ICU overflow patients, as well as caring for the recovery patients coming out of the OR. Participant A captured this dual focus well,

...they're totally different patients so it's a totally different mindset taking care of an ICU patient as opposed to a recovery room patient. So, you have to switch gears in that your goals are different...almost switching mindset to mindset...so you're doing double duty so you can't really focus on having an ICU patient.

This idea of having to focus on multiple patient populations and switch between two different types of nursing was expressed by every participant. Participant D spoke about the dilemma that this dual focus / dual duty created for her. She struggled with not being able to

give due attention to each patient under her care, particularly when vulnerable patients coming out of anaesthetic required her undivided attention,

...then there's the added issue that we are still looking after the post anesthetic patients coming in the door so how do you focus on that patient and still admit new post-ops, new post-ops that may have an airway issue which is the primary issue. You've got to have air or you are dead.

She spoke of the difficulty this posed for her when she was also responsible for an ICU patient.

You can't focus on either one, and if you can't focus on either one how do you give good care to either? You don't, you don't, somebody suffers and you hope that you are not going to have a problem, you just wing it and hope for the best....hoping the ventilator doesn't do something funny or the patient doesn't and then the alarm's going off and you're thinking *oh my gosh what is going on over there?*

For this participant the dual focus meant that at any point in time she was forced to simply trust and hope that nothing bad would happen, a situation that created feelings of stress and anxiety.

Specialty Practice

The theme of Specialty Practice was constructed from participants discussing the differences between the critical care areas. It is interesting to note that several of the nurses referred to the ICU nurses as critical care nurses which implied that they did not see themselves as critical care nurses. Other participants acknowledged that they were critical care nurses but went on to clarify that there was a difference between the different areas of critical care nursing. In this way participants experienced a tension between the idea that critical care is a homogenous speciality, as suggested by the requirement that they look after ICU patients, and their own experiences of each critical care area having a specialized knowledge and routine. The theme Specialty Practice is an attempt to capture this idea of specific knowledge and routines within specific critical care areas. The sub-theme of 'Doing but Not Knowing' provides a description of the specialized knowledge, procedures and skills that make a Recovery Room

nurse different from an ICU nurse and vice versa. The sub-theme of contextual differences provides a description of how the physical layout, location and available supports of the two units were described as specialized.

Doing but Not Knowing

Specialized routines included both skills and standardized practices. Several of the participants referred to their 'critical care clinical skills' being either absent or remote.

...there's a whole different set of skills that comes with a critical care patient than with a recovery room, I think, anyway. I mean you are a critical care nurse but in a different way (Participant A).

...you're a 'critical care nurse' quote unquote, it's different in whatever setting you're working in whether in emergency, ICU, or PARR" (Participant C).

Several participants spoke of the relationship between the frequency of performing a particular skill and the ability to stay competent in that skill. They felt that although this is common to all nursing practice areas, it is particularly difficult in the areas where there are many complex, technological skills. The Recovery Room magnifies this issue because of the infrequent nature of ICU overflow patients.

...when you do it so infrequently, once every six months say, it's hard to pull that back and remember all those things that give good quality care to someone who is critically ill" (Participant A).

Participant B spoke of learning how to do a bladder pressure at the bedside when it was ordered and then not seeing it again for six months.

....bladder pressures, we all learned that one just at the bedside because we had to. You know, things like that that come out of the blue that we never heard of before (Participant B).

Participant F stated:

...you can have an in-service and you might not have to use it for four to six months...to be proficient, you have to do it, you have to use it.

Staying competent within a specialty was only possible when the applicable skills could be practiced on a routine basis.

One of the things that characterized specialized practice from these participants' perspectives was standardized procedures and routines. All six participants talked about not being familiar with the ICU standardized practices and routines. Some spoke of having that knowledge in the past but having either forgotten it because it was remote or recognizing that practices and routines had changed since they had worked in the ICU. Participant A, who had the most recent experience in the ICU, spoke of order sets changing and parameters for things such as insulin infusions changing so it was difficult to keep up:

....it's a different skill set and starting insulin drips and different sets of orders which you are not always familiar with or are always changing.

The unfamiliarity of orders was compounded by the issue of not having enough time to learn the new orders and routines or having to learn them under pressure. This sometimes created a sense of being overwhelmed for participants. Participant C talked about feeling overwhelmed by the orders,

...there's nothing wrong with the orders, but when you're not used to them, when you're not orientated to them, I found it very overwhelming.

She went on to say:

....if their potassium was such you give - you give whatever medication to replace potassium or decrease the potassium...then having to go back and trying to familiarize yourself with what does this mean, what does that mean?

This participant talked about not even being able to find the order sets in the computer; when asked to print them off she had no idea where to find them.

Time constraints meant that participants had to provide care and follow protocols that they did not completely understand; Participant F speaks of learning as she goes

... to learn something at 2 or 3 o'clock in the morning for the benefit of the patient is not how it should be...I think all of us should have had some in-services on the drugs that are used, how they are used, different protocols, just everything instead of being thrown – here's the ICU orders now do it.

Participant D had a similar experience “....the standing orders to titrate drips according to new blood results, all those kinds of things I've learned on the job”.

There was a consistent expression of concern about not understanding the 'whole picture' but rather simply following order sets and protocols. Participants acknowledged that having the whole picture was an important distinguisher of clinical expertise. Participant F stated:

...we're just muddling along trying to keep the patient ventilated, vital signs stable, and not really understanding the whole picture.

An example of this idea of understanding the 'whole picture' or complexity of the patient was provided by participant A:

...someone whose kidney function isn't any good you probably wouldn't give them Ranitidine Q8H, as a critical care nurse, when you're in that all the time you think 'hey should we switch this to Q12H' or you'd be concerned, even though that's not my responsibility to know it, but that's knowledge I have, it would be a red flag to me that maybe I should address this.

These participants felt that the expert knowledge a nurse gains in a specialized setting helps to provide quality holistic care to the patient and in some cases averts medical errors.

Along with the ability to see the whole picture, the idea of being able to anticipate what you need before you need it as an important part of providing quality care was echoed in several interviews. Participant D spoke specifically of being able to anticipate the needs of a recovery room patient even when she felt tired from an extended shift but she did not have that ability with an ICU patient because she felt she didn't have that expertise.

It's not there right at the tip of your fingers like it is when I get a patient from the Recovery Room who needs this right now, I know what to do. I can do that. I can even anticipate they'll need a lot of that stuff, but I can't do that with an ICU patient because I have never worked in ICU....I have to get all prepared or look it up and find out how to – that's a waste of time when there's a situation that you need to deal with right now.

This inability to anticipate was particularly crucial in times of urgency; experienced nurses felt like novices as they struggled to stay ahead of rapidly changing conditions. Participant A also talked about being able to anticipate the needs of patients as being necessary to provide quality care to patients. She stated,

that's a whole different skills set, you know when to check sugars, knowing you know, a lot of times being a critical care nurse you anticipate what you need before you need it.

Participants also pondered whether their perceptions of excessive workload arose from their unfamiliarity with the ICU sub-specialty. For example, one participant was struggling with the fact that when only two nurses were working in the Recovery Room, one was expected to manage the ICU patient while the other was expected to manage incoming Recovery Room patients. However, in her experience, and because of her limited knowledge of ICU patients, often two nurses were required to perform the care. Having not worked in ICU, she did not know whether this was standard practice,

....we needed two nurses to manage that patient but I see an ICU nurse wouldn't necessarily require that because they're used to that or maybe they do. I don't know, I don't know what they do." (Participant D).

This quote, beyond simply reflecting on the practical lack of knowledge Recovery Room nurses sometimes had of the ICU specialty illustrates the dilemma nurses find themselves in as they try to determine their performance in relation to "normal" practice and overcome a sense of inadequacy.

Ironically, participants felt that even other critical care nurses did not necessarily understand the dynamic of sub-specialties within critical care, which furthered a potential sense of inadequacy. For example, participant B suggested that the ICU nurses would have just as many issues taking care of Recovery Room patients as they do taking care of ICU patients but they do not get the opportunity to find out. Participant C stated that she often felt judged by the ICU nurses after caring for an ICU patient overnight,

...the expectation from the ICU staff is that we should be doing it to their level, well we're not going to be able to anymore than they're able to come over and look after Recovery Room people the way we do it because we do it every day, they do ICU every day so I think there has to be a bit of give and take between the departments, we are not ICU north.

Contextual Supports

Contextual supports are an integral part of speciality practice. Every participant talked about the lack of support and resources they felt while caring for ICU overflow patients. These included knowledgeable colleagues, support personnel, specialized equipment, break relief and preparatory education.

One of the greatest challenges of caring for ICU patients in the PARR was not having experienced colleagues to consult. Nurses in ICU were surrounded by colleagues, a charge nurse, respiratory therapists and other resources to draw upon when in doubt. Participant A, a highly experienced nurse with fairly recent ICU experience spoke of the challenge of not having experienced colleagues to bounce ideas off of or to help mix medications. For example, she cited a situation where she was responsible for monitoring the perfusion of new skin flap but when the flap potentially deteriorated she was unable to access another experienced nurse for a second opinion, leading her to feel like she was working in isolation,

...that was not such a good experience because I felt I was responsible for that flap but normally there are so many people you would call, yeah that's what you do as nurses, and when you're up there you feel like you're floating by yourself.

Even when contextual supports were missing, as experienced nurses they still felt responsible for the care being provided and for patient outcomes. The idea of working with only one other nurse, who may or may not have ICU experience, made nurses feel alone. Participants identified nights as being less supported than days; most nights there are only two Recovery Room nurses working. This feeling of being isolated from colleagues was exacerbated by the fact that the Recovery Room itself was physically isolated from the other patient care areas.

If someone is crashing and you only have two people...it's you and one other person, you're far away, even though it's just down the hall but you're very far removed (Participant A).

Another important contextual factor that was perceived to be lacking was support personnel. Participants spoke of having no one available to obtain order sets from the computer and process orders. This role is fulfilled in the ICU by the unit clerk or the charge nurse when there is no unit clerk working. The nurses in the Recovery Room often had to print the orders from the computer for the physicians and then process the orders to ensure that pharmacy received medication orders, laboratory and radiology received test orders, and consultations to specialty services were completed, all while they were attempting to provide patient care. When the Recovery Room nurses tried to access personnel from outside of their unit to help them with the care of the ICU overflow patient they did not always feel supported,

...what I found overwhelming were the orders...we did ask the unit clerk in ICU to process the orders and she refused to (Participant C).

The lack of resources included access to specialized medications as well as equipment such as pressure lines and ICU infusion pumps. The ICU has a Pyxis machine which holds a wide variety of medications so the nurses are able to access medications at any hour of the day or night. The Recovery Room does not have a Pyxis machine so the nurses do not have access to medications within their unit; they are reliant on having someone bring them the medication or having to go themselves to get the medication from pharmacy or the ICU. This contributed further to a sense of isolation. "You feel like you're floating by yourself in there" (Participant A).

A few of the participants talked about not having anyone to cover breaks so they did not get breaks. Several of the participants spoke of a time when the Utilization Care Management Nurse (UCMN) or Nursing Supervisor was clinically capable of stepping in to support the nurses but felt that this was no longer the case. Many of the participants felt that the UCMN did not truly understand the complexity of the care of the patient because he/she had never worked in critical care.

I don't believe the UCMNs are as clinically capable as some of the ones in the past may have been to know what to do and how to help us or any other nurses...people are coming into the UCMN role to manage numbers... (Participant B).

All but one participant said that they were unable to obtain support from the ICU for breaks because the nurses in ICU were too busy to come and help; one felt that her request for help was not taken seriously by the ICU staff. There was one participant who felt that she got the help that she needed from the ICU when she asked. This participant stated that she was aware that this was not the experience of some other Recovery Room nurses but this had been her experience.

Finally, participants identified a lack of educational support. Four of the six participants talked about there being no preparation or discussion about this change in practice prior to it occurring. Participant D indicated that she knew the change was coming when there was talk of potential rotation changes to cover 24 hours but nothing was ever said by management,

...and the other thing would have been to say upfront that that's what the expectation is going to be, not that we're going to go to a day/night day/evening and then sort of say, once you've got that on board, then yes, this is what you're going to be doing. Nah, that's not good change process.

This participant expressed concern about the change process, and in particular that she felt the change occurred surreptitiously. This feeling of not being supported by the management was expressed by Participant A,

....when this whole thing started to happen a few of them approached our manager and said 'we want some education, we want to know if this is going to be a common practice and we're expected to take care of these patients, then we want a refresher....and basically the attitude was, if you don't feel like you can care for these patients, then you can't be working here.

Participant A also spoke of the lack of preliminary work around this practice change,

....let's do some education so when it does happen we know that everyone's prepared and there's support....but none of that happened, no conversation, no education, just this is what it is and deal with it.

So not only was there a lack of perceived support but also a perceived lack of any willingness to hear concerns.

Participants were further puzzled by educational decisions made by those in charge. Participant A saw irony in the amount of education provided for some smaller equipment changes when no education was provided to nurses who would now be caring for critically ill patients. Participant A stated:

....hey we're changing the glucometer and we're going to have education sessions every Tuesday and Thursday for the next couple of weeks so everyone is familiar...and that's with a glucometer, and bringing critically ill people into an environment in which people haven't cared for them in fifteen years and then saying 'well no you don't get any education, get used to it'. Well we had two weeks of education for a glucometer but you're not going to give me a couple of days of education to care for critically ill patients.

Participant F stated:

I think all of us should have had some in-services on the drugs that are used, how they're used, different protocols, just everything instead of being thrown here's the ICU orders now do it.

The idea of needing education of ICU order sets, paperwork, protocols, procedures, and equipment was repeated throughout the interviews. The educational priorities of the institution clearly did not align with that of the participants in this situation.

Most of the participants felt that there was no effort being made to address the lack of contextual supports. No plans were in place to provide personnel support for providing clinical expertise, processing paperwork, helping with workload, or break relief; to ensure timely access to ordered medications and needed equipment and supplies. There was also a feeling that staff were not being backed up when a decision was made. For example, one participant had decided that further staffing support was necessary in light of the acuity and workload but she was later questioned about her decision.

When you've got lots of years under your belt, people expect you to know what you're doing, but if you're not going to be backed up when you do say, 'okay this is my decision and I'm making this decision' and you're not being backed up by your manager or your PCC over that decision then, you know, let them come in and do it (Participant B).

This sense of not being able to make decisions in light of the changing practice requirements furthered the sense of not being adequately supported.

The nurses used a variety of tactics trying to deal with this change in practice. Some were focused on finding solutions to immediate problems such as using Google or resource books and binders to search for information. Some called specific units for information or help such as ICU when caring for an ICU overflow patient or calling the Obstetrics ward to come and care for a post c-section so the PARR nurse could focus on the ICU overflow patient. Some asked the physician to guide them through a new procedure to ensure patient safety. Five of the participants said they had called the UCMN to ask for help with processing orders, personnel support, and accessing medications, equipment, and supplies.

There were two participants who completed Professional Responsibility Forms (PRFs) each time there was an ICU overflow patient in an attempt to stop what they believe is an unsafe practice. Neither of them felt that the process had brought about change but both felt that it was important to continue to document their concerns.

Unit Culture

The unit culture within the PARR was constructed as a theme from the data collected. The PARR nurses self-perception and how they interacted with those from outside of the PARR seemed to contribute to their experience of this practice change. The theme of Unit Culture was broken down into the sub-themes of Identity and Relationships. The sub-themes of identity and Relationships were identified as contributing factors to the participants' experiences in caring for the ICU overflow patients.

Identity

The participants spoke of the Recovery Room as a unique and specialized unit with its own routines and practices that were being lost with the new practice of caring for ICU overflow

patients. The participants spoke of a sense of loss of identity and a devaluing of the expertise of the Recovery Room nurse. Participant B in particular spoke of this lost identity of the PARR nurse when she expressed a feeling that the expertise of the PARR nurse was not understood or valued by management,

I think they feel that it's not a big deal to just wake someone up from anesthetic, that doesn't, you know, take any expertise; it's when you get an ICU case, that's when you will really show what you can do...I feel undervalued, I feel that I'm ignored a lot" (Participant B).

This feeling of being undervalued was compounded by a sense of a loss of autonomy. Participant B explained that the movement of patients out of the unit used to be the decision of the Recovery Room nurse but now that decision is being made by the Manager or the UCMN.

Relationships

The relationship between the PARR and the ICU was a source of concern that seemed to exacerbate the difficulties encountered. The already difficult relationship between the two was further strained by PARR nurses feeling that they were being taken advantage of and the challenges this presented for morale. Participant A discussed the effect of this relationship on her experience in caring for ICU overflow patients. She felt there was a feeling that within the PARR that the nurses were being taken advantage of by people outside of the unit and that they were being 'dumped on'. She spoke of feeling 'frazzled' before she even started caring for the patient because of all of the negativity surrounding the decision to keep ICU patients in the recovery room. However, she also recognized the political nature of this negativity and how it detracted from the quality of patient care,

...it comes down to the patient and we need to at least stay focused on that and sometimes we get focused off of that and onto politics" (Participant A).

Three of the participants expressed concern about difficult relationships between PARR staff and ICU staff. Indeed, the language that they used indicated the extent of the challenging relationship.

I know there's not a very good relationship between ICU and PARR because ICU thinks PARR are whiners and PARR thinks ICU is toxic (Participant A).

Improving this relationship was seen as a way of improving the care of the ICU overflow patient by these three participants. Many participants expressed a belief that ICU was a potential source of needed support but they were unable to access this resource because of the poor relationship between the units.

Participant B stated that she often felt that Recovery Room nurses are seen as lazy because sometimes they do not have any patients while they were waiting for surgeries to finish; she expressed frustration that the nature of their work was not well understood. There is a sense that nurses in the Recovery Room work in isolation and that people from outside the department do not understand the patient flow patterns they experience. There is a belief that this lack of understanding has contributed to the poor relationship described between ICU and Recovery Room nurses. The strained relationship at times extended to the relationship between the Recovery Room nurses and the ICU physicians. Participant C stated,

....you've got doctors coming in from the outside who are coming into the territory of the recovery room....I feel like they're coming into our territory. They wouldn't like us coming into their territory, but they're coming into our territory.

She refers to the activity surrounding the care of the ICU overflow patient as "extraneous kafuffle". Participant C goes on to describe the experience,

...it's just overwhelming having them all there at the same time. Everything going on and kind of shoving out the Anesthetist, now we're having to take orders from an intern that we don't know who doesn't know us...

This nurse attributes some of the anxiety she feels to the disruption that occurs when ICU patients are kept in the Recovery Room; specifically the side-lining of the anaesthesiologists who normally direct care. Participant C clearly states that she sees the ICU physicians as outsiders coming into their territory and disrupting normal practices.

While many ideas were expressed during the participant interviews the themes of expert mind-set, specialty practice and unit culture arose from the data. These findings reflect the

experience of the nurses who participated in this study as accurately as possible. It is the intent of this study to give words to this experience of these nurses; the analysis of this data attempts to provide meaning to this experience.

Discussion

The purpose of this research study was to explore how the Registered Nurses in a mid-sized Recovery Room in western Canada managed the change in practice of caring for ICU patients overnight in the Recovery Room. Semi-structured interviews were used to gain a deeper understanding of the nurses' experiences. Although the experiences varied, there were some themes that were echoed by many or all of the participants. It is my intent to discuss these themes in greater depth through an exploration of existing literature. This analysis will provide a clearer understanding of the experiences of these nurses, in this particular setting, during a particular period of time.

This discussion will explore the dilemmas of 'Knowing but not Doing' and 'Doing but not Knowing'. 'Knowing but not Doing' explores the idea of understanding what quality care is but being unable to provide that care because of reasons perceived to be beyond the control of the nurse. 'Doing but not Knowing' explores the idea of being able to perform the necessary tasks to care for a patient but feeling unable to understand the big picture because of a lack of expertise with a specific patient population. This interpretation of the data gathered from this study will provide a deeper understanding of these experiences described by the participants.

Knowing but Not Doing: The Dilemma of Not Being Able to Deliver a Standard of Care

Nurses in this study experienced a sense of distress when they felt unable to provide the same level of care to the ICU overflow patients as they do the Recovery Room patients. Many of the participants talked about the care being provided to ICU overflow patients in the Recovery Room as unsafe. Some spoke of knowing what quality care looked like based upon their ICU experience but felt unable to deliver that care. Participants described having to learn new skills in the middle of the night while caring for these patients, not having the necessary knowledge at their finger tips, and not being able to predict the needs of this patient population. Participants used words like stressful, wearing, and overwhelming to describe their experiences of caring for

the ICU patients. There was also a sense of feeling alone and unsupported, in part because of the physical isolation and lack of resources available to them in the Recovery Room.

The distress described by the participants of not being able to provide the level of care they wanted to provide may be referred to as moral distress. The phrase 'moral distress' has been widely used in the literature to describe broad, nonspecific experiences. In this discussion moral distress will be defined as follows, "moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (Jameton, 1984, p.6).

Several of the nurses spoke openly about their feeling that administrative decisions prevented these ICU overflow patients from receiving a high level of quality care. There was a sense that the decisions made regarding the care of the overflow patients were out of their hands, and yet they carried the distress that arose out of a perception that they were giving lower quality of care. Liaschenko and Peter (2004) wrote an article for the Journal of Advanced Practice concerning nursing ethics and conceptualizations of nursing that shed light on this aspect of moral distress. In this article, they discussed the changing historical conceptualizations of nursing as a vocation, a profession, and a practice. They suggested that how nurses view their work and their responsibilities within that work influences the degree of moral distress they feel. They specifically discussed the limitations of the view of nursing as a profession or a practice in the current health care environment. Autonomy of practice is one of the key characteristics of a profession. However, decisions around patient flow, educational requirements, and staffing ratios are organizational decisions and are thus outside of professional autonomy. The view of nurses as autonomous professionals who alone are responsible for the quality of care provided ignores the responsibility that belongs to the healthcare organizations within which nurses do their work. Conceptualizing nursing as work rather than a profession may help with this change in perspective. The professional view "represents individuals as autonomous and distinct from the organizations...the worker view

represents individuals as extensions of organizations” (Liaschenko and Peter, 2004, p.493).

Nurses who view themselves as workers are less likely to shoulder a burden of responsibility for the quality of care that they cannot control.

Davis, Fowler, and Aroskar (2010) in a chapter called ‘Professional Ethics and Institutional Constraints in Nursing Practice’ discussed the multiple and sometimes conflicting ethical obligations experienced by nursing. The actions of the registered nurse are guided by a code of ethics outlined by governing bodies such as the American Nurses Association (ANA) or Canadian Nurses Association (CNA); the ethical board of the employer or institution for which they work; and the ethical decisions made by the ordering physician. I would add that the nurse’s personal moral obligation should be added to this list. For nurses in this study the conflict arose as a result of conflicting obligations between his/her own perceptions of quality care and what was realistic within institutional constraints. When there is conflict between these obligations the nurse is left in the powerless position of providing care to a patient which is felt by the nurse to be less than best for the patient.

Yarling and McElmurry (1986), in an earlier work on morality and nursing made the inflammatory statement, “nurses are not free to be moral” in hospitals. They clarify that they are not speaking about freedom of will but rather freedom of *action*. Data from participants in this study suggested that they would agree with this claim. However, perhaps we should use the work of Liaschenko and Peter (2004) to ask why nurses feel morally responsible for decisions that are not theirs to make? Nurses are free to act morally in their care and advocacy for the patient but they cannot be held morally responsible for organizational or medical decisions. Nursing is not alone in this dilemma; Hoff (2001) wrote about a similar reality for the medical profession within the current healthcare environment. Autonomy of practice is not a reality in many decisions made by the physician; they also must work within a system where decisions are often made at an organizational level that limits their allowable options.

Ideas about moral distress and proximity further illuminate these findings. Peter and Liaschenko (2004) discussed the idea that organizational decisions are made regarding distribution of resources and care strategies from a distance; but it is the nurse at the bedside who experiences the reality of the consequences of those decisions. They explored the disconnect between administrative decisions and bedside nurses when they stated “the up-close viewpoint of patients and nurses as real people in real space and time can more easily be neglected when one is detached from the implications of choices made and one can view people as just numbers” (p. 221). The nurses who participated in this study were all senior nurses, five out of six of them had more than 20 years of nursing experience and four out of six of them had more than 11 years experience in the Recovery Room. These nurses knew what quality care looked like and in their proximity to the patient felt that this standard of care was not being realized. A sense of frustration arose out of feeling that those who made the decisions to keep ICU patients in the Recovery Room were distant from the impact of those decisions. This was typified in the Utilization Care Management Nurse (UCMN) or Night Supervisor making the decision to have ICU overflow patients stay in PARR but this group no longer had the expertise to step in and help with this care and so never felt the impact of this decision.

Adding to the complexity of this sense of moral distress is how this change in practice occurred. It is important to remember that this was a significant change in practice for the nurses in this study. It is possible that some of the intensity of the experiences described may be attributed to the implementation process of the change. Knight (1998) wrote about nursing lecturers experiencing a grief response when a major organizational upheaval occurred without warning or input from the staff.

Johnson (1998) wrote about the importance of staff participation when patient care models are changed. Three essential components to a successful change process are comprehensibility, manageability, and meaningfulness. Resistance from nurses decreases when they are informed of the plan for change, why the change is occurring, and when it will be

happening. The nurses must also believe that they will have the necessary resources to manage the change if they are going to take ownership and accept the purposed change. In this study the change occurred without following the necessary change principles described by Johnson.

Clear communication, opportunities for discussion, and adequate resources are also necessary components for successful change implementation (Curran-Smith & Best, 2004). Nurses must understand the benefit and purpose of the change if the change is going to be adopted into practice without resistance. If nurses feel a change is being pushed upon them the initial reaction will be to push back regardless of the merit of the change (Curran-Smith & Best). Participants in this study repeatedly spoke of there being no plan in place for this practice change. One day there were no available beds in the ICU, and so the Recovery Room became the place where ICU overflow patients were cared for by Recovery Room nurses. The nurses felt that there was no plan for education regarding the care of the complex ICU patient; necessary resources such as immediate availability of medications and supplies were not put into place; and there was no access to personnel such as a ward clerk to help process paperwork or a critical care nurse to cover for breaks. One participant even felt that a rotation change was planned in preparation to this practice change but the nurses in the Recovery Room were never told the change was coming.

Back in 1951 Kurt Lewin developed a change theory which remains the foundational model of change. This theoretical model describes the three stages of planned change as unfreeze, transition, and freeze. Without minimizing the moral distress that the nurses in this study felt over a perceived lower quality of care, it is also important to consider the impact of the lack of following planned change theory. It is possible that the resistance seen to this practice change was also a response to the change process. Already feeling disempowered by their lack of participation in the planned change, these participants felt the gap between what they knew should be happening and what they could do about it even more acutely.

Doing but Not Knowing: The Dilemma of Generalist versus Specialist in Critical Care Practice

One of the dilemmas within generalist nursing is whether ‘a nurse is a nurse is a nurse.’ That is, how much can nurses be competent and confident across practice areas without additional preparation? A similar question arose in this study. Participants talked about not being able to provide the same level of care to the ICU overflow patient as they could to a Recovery Room patient even though all of the participants identified themselves as critical care nurses. Despite the commonality of being a critical care nurse, each participant spoke of the differences between critical care areas. This idea gives rise to the question of sub-specialties within the umbrella term of critical care. The expertise these nurses have in the sub-specialty of Recovery Room nursing did not necessarily translate into expertise in ICU nursing.

The idea of the expert nurse is not new. The Novice to Expert model of nursing practice developed by Patricia Benner (1982) has been used throughout nursing since it first appeared in the literature. The foundation of this model is that education and experience are necessary components of the expert nurse. Benner, Tanner, and Chesla (2009) described expert nursing practice as intuitive links between seeing a situation and then responding appropriately, sometimes not conscious of having made a decision. Benner et al wrote of ‘clinical grasp and response-based practice’; ‘embodied know-how; ‘seeing the big picture;’ and ‘seeing the unexpected’ as key aspects of expert nursing practice.

‘Clinical grasp and response-based practice’ involves the nurse possessing a full understanding of a clinical situation but then revising expectations based on the individual patient’s response. The expert nurse anticipates the patient’s response to a particular clinical situation and then modifies these expectations, in real time, for a particular patient based on her/his actual response. In ICU, an important aspect of the clinical grasp is the standing orders; nurses are expected to respond to patient situations using a standard set of physician orders. Participant C talked extensively about feeling overwhelmed by the order sets used for ICU

patients. The ICU nurse would have had those orders printed off and ready to be completed in anticipation of the complex needs of the patient. Many of the standing orders would have been initiated prior to the physician ordering them because the ICU nurse understands the common needs of this patient population. Specific orders such as electrolyte replacement would be anticipated and lab results would be watched so replacements could be started quickly if needed. However, participant C spoke of not even knowing where to find those orders and having to request them from ICU. So, although the Recovery Room nurse may be able to enact the orders at a competent level, it is the efficient initiation of the orders and the ability to rapidly respond to changes when using them that distinguishes expert nursing practice.

The second aspect discussed by Benner et al (2009) is 'embodied know-how'. This is described as fluid performance of skills which the expert nurse does under time pressure. A specific skill such as hanging a blood pressure medication is not considered expert practice; rather it is the nurses' ability to anticipate the need for that medication and then to titrate the infusion when a patient is rapidly deteriorating that demonstrates expert practice. Benner et al stated that this 'embodied know-how' is attainable only through practice. Participant D talked about being able to anticipate the needs of the Recovery Room patient even when she was extremely tired. But, she was not able to anticipate the needs of the ICU overflow patient and there was often a delay in intervention as she had to seek out resources and information for unfamiliar situations. She spoke of the 'know-how' not being at her finger tips. These delays are particularly distressing for nurses who are experts in responding to rapidly changing situations, a hallmark of good critical care nursing.

The third aspect of expert practice according to Benner et al (2009) is 'seeing the big picture'. Participant F spoke specifically of trying to perform unfamiliar tasks and just trying to get through the shift without really understanding the whole picture. Participant A, having the most recent ICU experience, talked about having the knowledge that a particular medication dose should be altered for patients with renal dysfunction but feeling this knowledge becoming

distant since it is not commonly part of her practice in the Recovery Room. She knew enough to grasp the relevance of the situation but expressed concern that this may not be the case for other Recovery Room nurses who have not worked in the ICU for many years or maybe ever. Seeing the big picture extends beyond the individual patient to having 'peripheral vision' which means sensing the needs of other patients in the unit and the capabilities of the nurses caring for them. There are nurses at different levels of ability in any unit and the expert is able to recognize when a more junior nurse needs assistance. This idea of the expert nurse being a resource and support for more junior nurses was seen in the data from this study. The nurses who were expert Recovery Room nurses felt that they should be a resource for newer nurses but then felt distressed because they did not feel that they were experts in caring for the ICU overflow patient. Participant B talked about younger nurses depending on her to tell them what to do but not knowing what to tell them.

The final aspect of expert nursing discussed by Benner et al (2009) is 'seeing the unexpected'. The expert nurses will notice sometimes subtle changes that indicate a patient is not responding as expected. The expert nurse becomes attuned to the subtle changes in the patients' status. This is often referred to as intuition but the nurse has taken these subtle cues and has put them together to see a pattern. This ability to pick up these cues is from repeated experiences in his/her practice. The expert Recovery Room nurse is able to pick up these changes in the patient population in the Recovery Room. It is that repeated experience with a specific patient population that allows the nurse to become attuned to patterns of response and subtle changes that suggest the pattern is disrupted. This was highlighted by participant A when she spoke of feeling like a novice nurse when conditions were changing rapidly. She was aware of the complexity of caring for the ICU patient but felt out of practice in her assessment and response to changing conditions. Participant F spoke of muddling along following orders but not really understanding the order sets. There was a sense that the nurse followed each order in a linear fashion but with limited assessment and intervention.

Many of the participants talked about not feeling competent to care for these ICU overflow patient during their interviews. As mentioned earlier competence was not the focus of this study but when looking at the Benner model it may be fair to say that these nurses were not 'expert' in the care of this patient population. It would be important to note that these nurses would be considered experts in the care of the Recovery Room patient using the Benner criteria; perhaps feeling anything less than expert contributed to the feeling of incompetence expressed by these participants.

Beyond the expert abilities of the nurse, there are important contextual supports for expert practice. Morrison and Symes (2011) completed an integrative review of the literature on expert nursing practice, building on a framework originally developed by Manley et al (2005). This integrative review looked at available literature on the common characteristics of nursing specialties and work settings. Within that framework are the 'environmental factors' which support expert practice. Morrison and Symes concluded that necessary environmental factors for the development of expert nursing practice include nursing leadership, autonomy, positive nurse-physician relationships, role models, and recognition. Descriptions of many of these environmental factors were found in the data under the sub-theme 'Contextual Supports'. Participants felt that education about the specialized routines, protocols, and order sets of the ICU was absent. Participant A spoke specifically of Recovery Room nurses asking the manager for education on the ICU order sets and protocols but the request was denied. The lack of planning around availability of break coverage, support staff, supplies, and medication was perceived as a lack of leadership in this practice change. The participants stated that they made requests for a nurse to cover for breaks or for the ICU unit clerk to help process orders but they were told the ICU was too busy and there was no one available.

The relationship between the recovery room and the ICU seemed to aggravate this feeling of not being supported. The participants spoke of not being taken seriously when they requested help. Since the ICU and recovery room share the same manager the participants

suggested that the leadership did not understand their needs and therefore could not provide the needed support. There was also a sense of us and them when it came to the relationship between the Recovery Room nurses and the physicians. Participant C described the physicians from the ICU as outsiders coming into their territory. She spoke of not knowing these doctors and these doctors not knowing the Recovery Room nurses. While this participant talked about not feeling supported she also talked about feeling overwhelmed by the number of physicians at the bedside. There was a sense that she felt the physicians were not a support but rather a source of more stress and 'kaffuffle'.

The issue of whether there are subspecialties within critical care nursing is not a trivial one because of its implications for nursing education. The question arises of how much responsibility lies with the individual nurse for lifelong learning and how much responsibility lies with the organization to prepare nurses for care situations outside of their primary expertise. Participants in this study expressed frustration with the lack of education they received for this significant change, particularly when other skills that could have been construed as part of lifelong learning (e.g. new glucometer machines) were emphasized by the organization. There seems to be a disconnect between needs of the organization and needs of the participants when determining the priorities for education.

There is no question that ongoing education is necessary to practice safely and competently in the ever-changing world of health care. Some licensing bodies try to address this ongoing need for new knowledge by requiring 'continuing nursing education' (CNE) credits which must be submitted annually to maintain an active nursing license. Specialty certification from the Canadian Nurses Association (CNA) requires a specified number of continuing education hours to maintain that certification. Registered Nurses in British Columbia are licensed by the College of Registered Nurses of British Columbia (CRNBC) which has an annual requirement of self-evaluation, assessment of learning needs, and continuing education to meet those needs. This licensing college holds a belief that it is the nurses' professional

responsibility to ensure that his/her knowledge is current and appropriate to practice safely and competently. This approach reflects the principle of lifelong learning rather than simply counting continuing education hours.

Jarvis (2005) wrote extensively on the concept of lifelong learning versus continuing education. She differentiates these terms primarily by identifying who has determined the content of the material. Lifelong learning involves the nurse identifying learning needs and then seeking out the necessary resources to meet those needs. Continuing education involves the manager or educator identifying the learning needs and then providing the nurse with the opportunity to gain that knowledge. Several of the participants spoke of not receiving any notice that this change was coming. From this perspective it would be difficult for the participants to assess and address educational needs until after the change had already occurred. Once the Recovery Room nurses started caring for the ICU overflow patients participants stated that they requested educational support to care for these patients but it was refused. Participant A spoke of the nurses feeling judged for asking for education when they were told that if they felt they couldn't care for these patients then they should not be working in the Recovery Room at all.

Gopee (2002) showed a direct link between lifelong learning and enhancement of patient care so there should be no question that a culture of lifelong learning should be valued. I would suggest that it is the responsibility of both the organization and the nurse to ensure that a culture of lifelong learning is valued and supported. Gopee identified organizational factors such as education funding, in-house education, regular evaluation, career opportunities, and managerial support all significantly influencing the learning culture of a unit. These factors reflect the organization's value of education which will influence the individuals' value of education.

The identified learning needs of the nurse must be valued and resources must be made available to meet those needs. One of the participants spoke of seeking out resources such as Google to obtain current information in a timely and efficient manner. This may work for many

things but it would not address the issue of unfamiliar order sets and protocols that are specific to this hospital. I suggest it is the responsibility of management to ensure information is available in an efficient manner, but it is the responsibility of the nurse to take the initiative to find necessary information and knowledge when needed.

The analysis of this data explored the concepts of Knowing but not Doing and Doing but not Knowing as they pertained to this specific Recovery Room during a practice change. This interpretation of the description of these participants' experience is hoped to deepen our understanding how to support nurses during a practice change. It is my hope, that while not generalizable, these results build on and inform the knowledge regarding practice change found in the literature.

Limitations

This study had a number of limitations. First, it included only six participants from a unit with approximately 20 nurses. Specifically, the participants were all experienced Recovery Room nurses. The aim of this study was to include nurses with a wide range of experience in nursing as well as in the Recovery Room but this was not achieved.

Another limitation is that this study took place in one Recovery Room in a midsized hospital in western Canada. For this reason it was treated as a case study to ensure that findings were considered specific to the experience of the participating nurses. There can be no generalization of the results to other Recovery Rooms in other facilities. The actual safety and/or competence of the care was not explored, there was no analysis of safety completed. I feel it is important to emphasize that the accuracy of statements concerning safety and competence were not the objective of this study. The focus of this study was the experience as lived by the nurse caring for the ICU overflow patients not whether the circumstances described by that nurse met with predetermined criteria for unsafe or incompetent care.

Finally, there is the limitation of only providing the perspective of the Recovery Room nurse. There were no other perspectives addressed by the data. The management/administration were not interviewed regarding their decision making process. The ICU nurses were not interviewed to understand their experience with having ICU patients cared for by nurses in the Recovery Room. Again, this study focused entirely on the experience of the recovery room nurses.

Implications

The implications of this study are multifaceted. Implications include the use of a change model when implementing a practice change; developing relationships to support practice change; valuing a self-directed learning culture; and the importance of having resources and practice standards in place to support practice change.

This research demonstrates the importance of communicating planned practice changes. Using a change model to implement change has been shown to increase participant engagement and ownership (Knight, 1998). Through a thoughtful change process these nurses would have had the opportunity to assess and address their learning needs. This does not mean that they would have necessarily agreed with the change but it would have provided an opportunity to express concerns and be heard. Successful change needs engagement during the planning, implementation and evaluation phase.

While these results cannot be generalized they may be transferable to any health care setting where a practice change is being implemented. This study demonstrated the importance of effective communication before and during a practice change. Engagement of the staff is a necessary ingredient to successful change implementation regardless of what the change is. Engagement requires that their input be gathered before, during and after the practice change and that communication flows in both directions.

This study also highlighted the importance of relationships between the recovery room nurses and management, the ICU nurses, and the ICU physicians. There seems to be a lack of trust between the different groups which has resulted in a perception of feeling unsupported in this practice change. Perceptions of everyone who is involved in the change must be considered. These groups would probably benefit from some group building exercises that would allow them to understand and value the contributions of all team members.

Adoption of a self-directed learning culture would also help with the implementation of practice changes. This study involved experienced Recovery Room nurses who identified very specific learning needs but felt unsupported in meeting those needs. These nurses expressed feeling unheard and devalued when they brought concerns forward. There must be a forum available for these nurses to discuss their concerns without feeling judged by their manager and ICU colleagues. Many felt they had ideas that could address their concerns but there were no forums available for them to present these ideas.

To expand on the idea of feeling supported through this change the Recovery Room nurses perceived a lack of timely and efficient access to information concerning order sets and protocols as a major obstacle to providing quality care. There must be a system in place where the nurses can access information about practice standards, order sets and protocols quickly. It was noted that many of the order sets and protocols change frequently so it must be a system that is maintained and contains accurate and current information. This organization is currently working on a website that would be a portal to such information but it has been a long term project and is still not ready for implementation. This research supports the importance of this project and suggests that its implementation be made a priority to ensure necessary information resources are readily available to the nurses at the bedside.

Participants in this study felt distressed when they had to provide care to the ICU overflow patients in the Recovery Room. They expressed concern that they felt unable to provide quality care to these patients. As stated earlier the actual quality of care was not the

focus of this study but if the nurses perceived that patient care was compromised then it is real for them. In a literature review of 21 studies Utrainen and Kyngas (2009) had identified quality patient care as an important indicator of job satisfaction in nursing. The perception of compromised patient care could lead to decreased job satisfaction resulting in nurses leaving this area of nursing.

Further study into the practice of caring for ICU overflow patients in the Recovery Room is needed. The scenario of having more patients than beds is not a unique problem to this hospital. The ICU patient population is one of the most vulnerable groups and requires specialized care to ensure quality care is provided. The Recovery Room nurse is a valuable asset in the health care system and steps need to be made to address the distress being experienced by these nurses. More research is needed to better understand how these patients and nurses can best be supported.

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Appendices

Appendix A: Nurse Information Brochure



Faculty of Health and Social Development
School of Nursing
3333 University Way
Kelowna, BC V1V 1V7
Tel: (250) 807-8077 Fax: (250) 807-8085
www.ubc.ca/okanagan

Title of Research Project: ICU Patients in the Post-Anesthetic Recovery Room: A Case Study Exploring how Registered Nurses Manage Change.

Principal Investigator and Supervisor: **Dr. Barb Pesut** - Assistant Professor
University of British Columbia Okanagan.

Email: Barb.Pesut@ubc.ca

Co-Investigators: **Crystal White**, RN, Clinical Nurse Educator, Intensive Care Unit, Kelowna General Hospital, MsN Candidate, University of British Columbia Okanagan.
Phone (250) 862-4300, local 2308
Email: Crystal.White@interiorhealth.ca

Dr. Kathy Rush – Associate Professor
University of British Columbia Okanagan
Email: Kathy.Rush@ubc.ca

Nancy Serwo – Health Services Director
Kelowna General Hospital
Email: Nancy.Serwo@interiorhealth.ca

What Is This Study About?

This research will explore this practice change of caring for ICU patients in the PARR as experienced by the PARR nurses in a mid-sized western Canadian hospital. The purpose of this research is to develop a better understanding of how the Recovery Room nurses experienced and managed the practice change of having to care for complex surgical and medical ICU patients in the PARR.

Who Can Participate?

To participate in this study:

You must be Registered Nurse working in the (PARR) at Kelowna General Hospital in a full-time or part-time position and do not concurrently work in the ICU. You must have cared for an ICU overflow patient in the PARR between January 2009 and December 2009.

What Will I Be Asked To Do?

- Participate in a face-to-face in-depth interview with the researcher (Crystal White).
- Answer questions about your experiences of caring for ICU overflow patients in the PARR
- Validate your responses in a follow-up interview.
- Commit about 30 minutes to 1 hour of your time for the initial interview and approximately 15 to 30 minutes for the validation interview.
- Agree to have the interview digitally recorded (audio) and later transcribed for analysis.
- Complete questions about your level of education and experience in nursing
- Sign a consent form.

What Do I Do If I Am Interested in Participating?

If you are interested in taking part in this study, please contact me, Crystal White (250) 862 4300 loc. 2308, or Crystal.White@interiorhealth.ca and I will send you a consent form with more details.

Appendix B: Consent and Information Form



**Faculty of Health and Social Development
School of Nursing**
3333 University Way
Kelowna, BC V1V 1V7
Tel: (250) 807-8077 Fax: (250) 807-8085
www.ubc.ca/okanagan

Title: ICU Patients in the Post-Anesthetic Recovery Room: A Case Study Exploring how Registered Nurses Manage Change.

Principal Investigator:

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Co-Investigators:

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Nancy Serwo – Health Services Director
Kelowna General Hospital
Email: Nancy.Serwo@interiorhealth.ca

Study Information and Purpose

This research will explore this practice change of caring for ICU patients in the PARR as experienced by the PARR nurses in a mid-sized western Canadian hospital. The purpose of this research is to develop a better understanding of how the Recovery Room nurses experienced and managed the practice change of having to care for complex surgical and medical ICU patients in the PARR. This study is part of Master's thesis in the Faculty of Nursing at the University of British Columbia Okanagan.

Who Can Participate?

To participate in this research study you must be a Registered Nurse working in a permanent position (either part-time or full-time) in the Post-Anesthetic Recovery Room at Kelowna General Hospital and have cared for an ICU patient in the PARR over the past year. There will be up to 10 Registered Nurses participating in this study.

What Does the Study Involve?

You will participate in an interview where I will ask you a few open-ended questions regarding your perception of the practice change experience. There will be questions regarding perceived changes to required knowledge, skills, and abilities for you to perform your job. You will also be prompted to discuss how you have managed these changes in practice as well as critique what you feel has supported your transition and what has hindered your success. All questions will be open-ended to allow you to expand on your experience. We may wish to use short quotes from the interview with your permission to do so.

I will take notes during and after the interviews. Interviews will take place at a time and place that is convenient for you. There is no right or wrong answer. The discussion will take approximately 30 minutes to 1 hour of your time. With your consent, our conversation will be digitally recorded (audio). After the preliminary findings are analyzed I will ask you to review findings to ensure the data reflects your responses during the interview; this follow up session will take approximately 15 to 30 minutes of your time. In addition you will be asked to complete a form that asks information about your level of education and experience in nursing.

Results of this study will be shared through publications and presentations; no identifying information regarding participations will be shared.

Risks

There are no perceived risks to participating in this study except perhaps the time involved.

Benefits

One of the benefits of participating in the study may be to increase your awareness of the change process. It is hoped that this exploration into a practice change will provide a better understanding of how to support nurses during a practice change. Participating in this study may help you to identify strategies that have allowed you to manage change more effectively. You will also receive a coffee card in appreciation of your participation in this study.

Confidentiality

A number of measures will be used to keep your identity confidential. The audio recordings and printed discussions will be kept in a locked cabinet in the researcher's home office and made available only to members of the research committee (as listed on the front page of this consent). Once the audio digital recordings are transcribed, the recordings will be double deleted from the digital recorder. The transcriptions will be stored in a password-protected format and will be backed up by a flash drive, where they will remain for the expected standard time frame of five years. In January 2015 they will be erased and destroyed by the researcher. This data will be destroyed by shredding the paper data, double deleting data from electronic data bases and burning the flash drive.

The printed discussions will use code numbers so no participant can be identified. All documents will be identified only by code number and kept in a locked filing cabinet. The code book will be kept in a separate locked drawer in a desk in the researcher's home office. The findings of the collected data will be shared with others who study and work with practice change in healthcare and be communicated in written papers or oral presentations. Short quotes from your interview may be used to provide context to the findings but all identifying information will be removed. We are asking your permission to communicate the findings in this way without personally identifying you. It is anticipated that results from the study will be used to guide future research in this area. If you would like a report of the findings please include your mailing address in the space provided at the end of this form. You will also be provided with a copy of the signed consent form.

Contact for information about the study:

For additional information or information any time during the study, please contact Crystal White (250) 862 4300 loc. 2308 or Barb Pesut (250) 807-9955.

Contact for concerns about the rights of research subjects:

If you have any concerns about your rights or treatment as a research subject, you may contact:

- Kristen Kane, Manager of UBC Okanagan Behavioural Research Ethics Board in the UBC Okanagan Research Services Office at (250) 807-8832 or e-mail to kristen.kane@ubc.ca.
- Chair of the Interior Health research Ethics Board at 250-870-4649.

Contact for concerns about the rights of research subjects:

If you have any concerns about your rights or treatment as a research subject, you may contact Kristen Kane, Manager of UBC Okanagan Behavioural Research Ethics Board in the UBC Okanagan Research Services Office at (250) 807-8832 or e-mail to kristen.kane@ubc.ca.

Withdrawal from the study

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time during the course of this study. There is no impact on your employment if you choose not to participate in the study, or if you withdraw from the study. Participants can drop out of the study at any time. If a participant decides to withdraw from the study, he/she will be asked at the time of withdrawal if the data already collected may be used in the study. If the participant does not want the data to be used in the study, the data will be destroyed at that time. Once the data analysis is complete, contributed data will no longer be able to be withdrawn.

Consent

Your signature below indicates that you have received a copy of this consent form for your own records.

Permission to record interviews_____ (Initial)

Do you agree to have short quotes used in disseminating the information gathered from the study? ☐ Yes ☐ No

Your signature indicates that you consent to participate in this study

Participant Signature _____ Date _____

Printed Name of the Participant

Witness Signature _____ Date _____

Address of Participant (For Sending Study Results)

Please provide an address if you would like a summary of the results of this study sent to you.

Thank you for your time!

Appendix C: Interview Guide

1. Tell me about any changes of practice in relation to ICU patients you have experienced over the last 12 – 18 months.
2. a. Can you tell me about a time this was a good experience?
b. Can you tell me about a time when this was a bad experience?

Prompts: Can you speak about the complexity of care required?
Can you remember the skill set required?
Were there external factors to how you felt? (personal stress)

3. What strategies did you use to manage these patients?
 - What worked well?
 - What didn't work well?
4. How has this change in practice affected you personally?
5. Do you have any ideas of how this change could be managed differently?
6. What haven't I asked you that I should have?

Appendix D: Participant Demographics

1. Highest Level of Education in Nursing:

- ☐ Diploma in Nursing or Associate Degree in Nursing (RN)
- ☐ Bachelor's Degree in Nursing
- ☐ Other _____

2. Have you completed Specialty Education?

- ☐ Yes ☐ No If yes, explain: _____

3. Years of Experience in Nursing:

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> < 2 years | <input type="checkbox"/> 11-15 years |
| <input type="checkbox"/> 2 – 5 years | <input type="checkbox"/> 16-20 years |
| <input type="checkbox"/> 6-10 years | <input type="checkbox"/> > 20 years |

4. Years of Experience in Post-Anesthetic Nursing:

- | | |
|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> < 2 years | <input type="checkbox"/> 11-15 years |
| <input type="checkbox"/> 2 – 5 years | <input type="checkbox"/> 16-20 years |
| <input type="checkbox"/> 6-10 years | <input type="checkbox"/> > 20 years |

5. Have you worked in an Intensive Care Unit (ICU)?

- ☐ Yes ☐ No

If yes. Number of years in ICU? _____ Dates: from _____ to _____

6. Do you currently work in any area of nursing other than the Recovery Room?

- ☐ Yes ☐ No If yes, where: _____