Orchestrating Care:

Nursing Practice with Hospitalized Older Adults

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ABSTRACT

The majority of recipients of nursing care in Canadian hospitals are older adults; however, research about nurses’ knowledge of aging, beliefs about aging, and institutional contexts and their influence on nursing care practice with older adults remains limited. In this study, grounded theory methods, guided by symbolic interactionism, were used to explore nursing practice with hospitalized older adults. The theory orchestrating care was developed after analysis of 375 hours of participant observations and 35 interviews with 24 participants.

The theory of orchestrating care explains how nurses are continuously trying to manage their work environment by understanding the status of the patients on their unit, mobilizing the assistance of others, and stretching available resources to resolve their problem of providing their patients with what they perceived as “good care” while sustaining themselves as “good” nurses in their practice that they described as hard, misunderstood, and under-resourced. They did this through the two subprocesses of building synergy and minimizing strain. Building synergy explains how nurses leverage and share information and gain the assistance of others. Minimizing strain explains how nurses use available resources, support and guide one another, and reframe their practices in ways that create a supportive nursing network.

Nurses looked for allies as they developed their lines of action to resolve their problem in work environments they characterized as problematic. When they did not regard other care providers and leaders as allies, nurses focused on their top priority of safety and turned inward for support from other nurses in the hope of relieving their feelings of being overwhelmed, pressured, ignored, and misunderstood. Turning inward to resolve their problem both aided the nurses (by providing short-term relief) and inhibited them (by increasing their isolation). It also
prevented them from articulating their challenges to their managers, from building synergy with other healthcare professionals, and from viewing their nursing team differently. Care of hospitalized older adults can be improved by listening to nurses who are working with this population, examining the hospital systems that constrain these nurses’ practice and from nurses critically reflecting on how their practices may be contributing to their challenges.
PREFACE

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example of aging that has served to cause me to question assumptions about aging and has illuminated the possibilities of living bolding to 100.
CHAPTER ONE: INTRODUCTION

As the population ages, nurses are increasingly being called upon to care for older adults. Older adults are the majority of healthcare recipients in most healthcare settings (Canadian Institutes of Health Research [CIHR], 2011; Denton & Spencer, 2010) due to the increased incidence of health challenges with increasing age (Barakzai & Fraser, 2008; Hickman, Newton, Halcomb, Chang, & Davidson, 2007). This is the case in hospitals, where two-thirds of registered nurses (RNs) in Canada are employed (Canadian Institute of Health Information [CIHI], 2008), suggesting that a significant portion of nursing practice is concerned with hospitalized older adults.

It is well known that nursing work is challenging. Institutional system issues can often prohibit nurses from delivering sometimes even the most basic nursing care, such as bathing or feeding their patients (Austin 2007; Austin, Bergum, & Goldberg, 2003; Rodney & Varcoe, 2012); however, nurses are able to influence their work environments and the care of their patients (Musto & Schreiber, 2012; Newton, Storch, Makaroff, & Pauly, 2012; O’Haire & Blackford, 2005; Peter & Liaschenko, 2004; Rodney & Varcoe, 2012; Rodney et al., 2013; Walsh, 2010). During my years of experience as an acute care bedside nurse, a manager, and a clinical nursing instructor, I have observed nurses overcoming many obstacles in their efforts to enact good care. In fact, it was my interest in supporting nurses’ practice with older adults that led me to graduate school. My master’s research clarified some of the challenges associated with caring for hospitalized older adults (Dahlke & Phinney, 2008), but as is often the case with preliminary research, it raised further questions about what influences nursing practice in this context. Those questions led to this current research project.
1.1 Significance of the Problem

Older adult care is particularly challenging because, with increasing age, people become more susceptible to complications related to their conditions, as well as to complications related to hospitalization (Amella, 2006; Barakzai & Fraser, 2008; Corsinovi et al., 2009; Fedarko, 2011; Graham, Ivey, & Neuhauser, 2009; Inouye, 2006; Wakefield & Holman, 2007; Walsh & Bruza, 2007). To some degree, complications result from hospitals not being organized to provide care to patients with chronic health conditions and their resulting complex needs (Chappell & Penning, 2001; Clarke, 2006; Peek, Higgins, Milson-Hawke, McMillan, & Harper, 2007; Sellman, 2009). On discharge, older adults are often at a lower level of functioning than they were on admission (Baztan, Swarez-Garcia, Lopez-Arrieta, Rodriguez-Manas, & Rodriguez-Artallijo, 2009; Ferrario, 2008; Gill, Gahbauer, Han, & Allore, 2011; Graham et al., 2009; Wakefield & Holman, 2007). Their reduced functional capacity means that they often need considerable support once they return home, resulting in increased burden for family caregivers (who may themselves be old), or in nursing home admission (Chappell, Gee, McDonald, & Stones, 2003; Gill et al., 2011; Health Council of Canada, 2008; Hollander, Chappell, Prince, & Shapiro, 2007; Northcott & Milliken, 1998; Sellman, Godsell, & Townley, 2005).

Scholars have suggested that older adults’ poor outcomes in traditional hospital units are related to patient-related factors, in combination with care provider and systems issues (Baztan et al., 2009; Hickman et al., 2007). Unfortunately, data collected by the Canadian Institute of Health Information (CIHI) to examine hospital care has focused on medical conditions, numbers of procedures, and how much time people spend in hospitals rather than the impact on people’s health (Health Council of Canada, 2008). In other words, the emphasis has been on efficiencies without overt consideration of the effectiveness of care delivery for the people who are most
likely to receive the care, leaving questions about the effectiveness of care delivered to hospitalized older adults. Taken together, the evidence seems clear that lack of attention to the needs of hospitalized older adults has negative ramifications for older adults and their families, and not effectively caring for older adults will in the end lead to inefficiencies for the healthcare system.

How to enact good care is a difficult question because the issues related to caring for hospitalized older adults are multifaceted (Baztan et al., 2009; Hickman et al., 2007). One of the important issues is the complexity of the presentation and care needs of acutely ill older adults. The physiological changes associated with aging may mean that older adults with acute illness present with different symptoms than are seen with younger people (Amella, 2006; Fedarko, 2011; Salzman, 2006). Older adults are also more likely to have underlying chronic illnesses that further complicate the clinical picture (Barakzai & Fraser, 2008; Fedarko, 2011; Ham, Sloane, & Warshaw, 2002). They may also have psychosocial concerns, such as limited income due to retirement, and loss of friends and family members from death (Chappell, Gee, McDonald, & Stones, 2003; Ham et al., 2002; Shaw, Krause, Liang, & Bennett, 2007) that limit their discharge options.

Unfortunately, the elements that contribute to the complexity of caring for older people are often overlooked or misinterpreted by healthcare professionals who have not been adequately educated about an aging population (Bernard, 2008; Deschodt, de Castele, & Milisen, 2010; Salzman, 2006). Problems are exacerbated when these care providers are practicing in a healthcare system that is not designed to fit the complex needs of older people (Chappell & Penning, 2001; Clarke, 2006; Peek et al., 2007; Wakefield & Holman, 2007). Moreover, negative perceptions about aging may be unconsciously perpetuated by healthcare professionals (Cherry
& Palmore, 2008; Kjorven, Rush, & Hole, 2011; Nelson, 2005; Wakefield & Holman, 2007). It has been argued that the acute care healthcare system is itself “institutionally ageist because those who do not fit the prescribed, almost industrial, model of hospital admission and discharge are identified as a problem” (Sellman, 2009, p. 70). Thus, it would seem that nursing practice with older adults is enacted by nurses who often lack knowledge about the specialized needs of an older population (Baumbusch & Andrusyszyn, 2002; King, 2004, Plonczynski et al., 2007; Gilje, Lacey, & Moore, 2007) within institutions where systems of care do not meet the complex needs of older adults and negative perceptions about aging are perpetuated.

1.2 Background

While nursing care of hospitalized older people is an important issue, it is an area of practice that remains poorly understood, in part because there has been very little research in this area. There are some studies that have explored how nursing practice with older adults may be influenced by nurses’ knowledge base and their perceptions about aging, as well as institutional factors.

McCarthy (2003) conducted a grounded theory study that suggested a link between nurses’ perceptions about aging, institutional supports within the care environment, and the meaning that nurses ascribed to cognitive changes observed in acutely ill older adults. McCarthy’s study used dimensional analysis to examine data from 28 nurses, with a study purpose of exploring the clinical reasoning of nurses who care for hospitalized older adults. The potential relationship between nurses’ perceptions and institutional factors is further supported by Boltz and colleagues (2008) who surveyed over 14,000 nurses to learn that nurses place more value on their work with older adults when they feel they have institutional support for this work.
Unfortunately, how this relationship influenced their practice was neither examined nor did the nurses report on the nature of these institutional supports.

McKenzie and colleagues (2011) examined institutional factors more directly in their study that compared nurses’ perceptions of geriatric care environments in three Canadian hospitals. They surveyed over 1,000 nurses to elicit their perceptions on institutional values about older adults and staff, institutional capacity for collaboration, availability of resources, and aging-sensitive care delivery. Overall, nurses’ perceptions either clustered around the midpoint of the scales or slightly toward the positive end of the measure (specifically in aging-sensitive care delivery and capacity for collaboration), leading these researchers to suggest that there is considerable room for improvement in providing both optimal care environments and aging-sensitive care. Although they suggest improvements are needed in these two areas, they did not examine the relationships between these two areas.

1.3 Statement of the Problem

While studies such as the ones I have cited above offer useful insights, many questions remain about how nurses navigate the challenging terrain of the acute hospital system to care for the complex needs of hospitalized older adults, and what supports and constrains their practice with an aging population. Nurses are involved in the care of hospitalized older adults around the clock; they have a pivotal role in positive outcomes for an aging population. Thus, research to better understand nursing practice with hospitalized older adults is a necessary step to improving older adult care and outcomes for an older population.
1.4 Purpose and Aim of the Study

The purpose of this study was to seek an explanation of nursing practice with hospitalized older adults by constructing a midrange substantive theory. The theory has the potential to explain the complexity of nursing practice with this population, thereby providing greater clarity about how to improve the care of hospitalized older adults and illuminating further research questions.

1.5 Theoretical Framework and Study Design

A grounded theory (GT) method, directed by the theoretical framework of symbolic interactionism (SI), was chosen for this inquiry. Researchers use SI to draw attention to shared symbols and meaning-making in social interactions (Blumer, 1969; Mead, 1934); GT (which is partially derived from SI) is a research method well suited for investigating complex human processes in order to inductively develop a theory about a phenomenon that is not well understood (Glaser & Strauss, 1967). In SI, individuals’ interactions are recognized as contributing to the collective social world (Blumer, 1969; Mead, 1934). Likewise, GT can assist researchers in understanding how participants manage the social problems they have identified (Glaser & Strauss, 1967). GT requires a researcher to develop a theory based on concepts that are grounded in data. Both GT and SI focus on how participants co-create meaning, construct behaviours, and interpret behaviours, making them well suited for this study of nursing practice with hospitalized older adults in the context of a socially constructed healthcare system.

1.6 Summary

Although nursing practice is increasingly concerned with the care of older adults, there has been inadequate attention paid to how nurses care for this population and the influence of institutional settings on their efforts to provide the care older adults require. A few studies have
suggested that perceptions about aging and institutional factors are negatively influencing nursing practice with an older population; however, these studies have not directly examined nurses’ perceptions of their practice or specifically identified what supports and constrains nurses’ practice with hospitalized older adults. There is a need to develop a contextualized understanding of how nurses perceive their practice with hospitalized older adults as a first step in improving older adult care.

In the next chapter, the research literature in the area of nursing practice with hospitalized older adults will be explored to outline what is currently understood about the issues. In Chapter Three, the theoretical framework of SI is explained, highlighting its appropriateness to guide this study. Chapter Four then provides an explanation of how the method of GT was used to conduct this study about nursing practice with hospitalized older adults. In Chapter Five I provide a detailed description of the settings and the study sample, and the substantive theory developed from the data is explained in Chapter Six. Finally, in Chapter Seven I present a discussion of the contributions of the substantive theory in the context of the literature, limitations of the study, and implications of the study for nursing practice, education, research, and policymakers.
CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Before the 1950s, when the specialties of gerontology and geriatrics emerged, there was little differentiation between general principles of nursing care and nursing care of older adults; literature that did address older adult care was confined to nursing home settings (Dahlke, 2011; Ebersole & Touhy, 2006). This narrow perception of older adult care has changed over time. Since 1952, when the first published nursing research on chronic disease in older adults appeared (Mack, 1952), the nursing profession has been steadily building an evidence base related to the care of hospitalized older adults. A search for current nursing research in this area identified over 8,000 research articles published up to and including the year 2010. Much of this research focuses on clinical problems associated with aging and specific strategies to deal with issues such as cognitive impairment, falls, incontinence, and pain management. As I have indicated in Chapter One, researchers have given minimal attention to understanding the issues related to enacting nursing practice with hospitalized older adults. While there is research exploring the clinical problems of an aging population, little is known about how nurses perceive and manage their practice with older adults.

As mentioned in the preceding chapter, providing nursing care for hospitalized older adults is complex. Although there is minimal research to help us understand this complexity, there are areas that have been identified as important to how nurses are able to practice with older adults. These areas include nurses’ knowledge of aging, perceptions about aging held by

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1 The term gerontology is associated with a broad social perspective of older adults and the term geriatrics is often associated with a medical approach to care of older adults (Ebersole & Touhy, 2006; Freeman, 1979; Morley, 2004).
nurses and by society in general, and institutional systems of care in the settings where nurses work. In this chapter, I will examine the literature related to these three areas.

2.2 Nursing Knowledge About Aging

While the literature is replete with evidence about problems associated with aging and suggestions about how to improve nursing care of older adults, it is unclear about the extent to which nurses have been exposed to this knowledge. There are three bodies of literature that are relevant to this question. First, a number of studies have suggested that knowledge about the specialized needs of older adults has not been provided in basic nursing education (Baumbusch & Andrusyszyn, 2002; Deschodt et al., 2010; Earthy, 1993; Ebersole & Touchy, 2006; Gilje et al., 2007; Ironside, Tagliareni, McLaughlin, King, & Mengel, 2010; Plonczynski et al., 2007; Xia, Patterson, Henderson, & Kelton, 2008). Second, there is a significant body of literature suggesting that the clinical environments where students are learning to provide nursing care have access to inadequate resources and are characterized by negative perspectives toward older adults, which can foster students’ negative perceptions about nursing practice with older adults (Aud, Bostick, Marek, & McDaniel, 2006; Brown, Nolan, Davies, Nolan, & Keady, 2008; Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009; McLafferty, 2005). Finally, there is a body of literature suggesting strategies to provide practicing nurses with information about the specialized needs of older adults. I will examine each of these areas in turn.

2.2.1 Basic Nursing Education

The majority of the gerontological nursing education literature originates from the United States (US), with a focus on how to incorporate gerontology content in nursing curricula (Aud et al., Barba & Gendler, 2006; Blais, Mikolaj, Jedicka, Strayer, & Stanek, 2006; Latimer & Thornlow, 2006). The focus is likely due to recommendations made over a decade ago that
nursing curricula should contain both a required gerontological course with theoretical and clinical content, and gerontological content threaded throughout the curriculum (American Association of College of Nursing [AACN], 2000).

Scholars who have examined nursing curricula have found a wide range of strategic challenges associated with equipping future nurses with an understanding of the unique needs of older adults (Deschodt et al., 2010; Kirkpatrick & Brown, 2004; Plonczynski et al., 2007; Williams, Anderson, & Day, 2007; Williams, Nowak, & Scobee, 2006). These challenges include: (a) finding adequate numbers of faculty who are academically prepared to teach older adult care (Baumbusch & Andrusyszyn, 2002; Deschodt et al., 2010; Gilje et al., 2007; Xiao et al., 2008); (b) adding further content to nursing curricula that are perceived as being already crowded with knowledge considered essential (Barba & Gendler, 2006; Deschodt et al., 2010); (c) choosing clinical experiences that avoid exposure of students to negative older adult care experiences (Aud et al., 2006; Brown et al., 2007; Ironside et al., 2010); (d) diminishing the negative image surrounding gerontological nursing (Brown, Nolan, & Davies, 2008; Deschodt et al., 2010; Flood & Clark, 2009; Ironside et al., 2010; Xiao et al., 2008); and (e) reducing perspectives holding that older adult care is both basic and simple (Brown et al., 2008; Xiao et al., 2008).

Earthly (1993) conducted the first survey of 22 baccalaureate nursing programs to determine the gerontological content in nursing curricula across Canada. Her research revealed that half of the schools claimed gerontological content was integrated throughout their curricula, two schools had a required gerontological nursing course, and seven schools offered elective gerontological courses. Unfortunately, only 5% of nursing faculty members had gerontological
preparation. Following up on Earthy’s study 10 years later, Baumbusch and Andrusyszyn (2002) recruited 21 baccalaureate nursing schools to respond to the same questionnaire. They found that there had been some improvement in gerontological content, with roughly half of the programs reporting required courses in gerontological nursing, and the remainder offering gerontological electives, and/or claiming they integrated gerontological content throughout the curriculum. The percentage of faculty members who had educational preparation in gerontology had improved only marginally. Both of these Canadian studies incorporated debates about integration of gerontological content in curricula and the challenges of teaching gerontology with small numbers of faculty members with expertise in this area. In recent years, there have been knowledge exchange workshops for nursing faculty as a first step in improving the gerontological content in Canadian schools of nursing (McCleary, McGilton, Boscart, & Oudshoorn, 2009).

Authors conducting a national survey of nursing schools in the US revealed problems similar to those of Canadian schools (Gilje et al., 2007). Over one-third of the accredited baccalaureate programs in the US responded, with half of these reporting that their curriculum offered a course about older adult care, while the other half reported that their curriculum integrated geriatric and gerontology content. Gilje and colleagues also identified the challenges of teaching older adult care with a paucity of faculty (less than 25%) who had academic preparation in gerontology. Although Gilje and colleagues (2007) felt their findings indicated there had been good progress over the last decade in incorporating content about older adults into nursing curricula, Plonczynski and colleagues’ (2007) study of a midwestern nursing program offered a different perspective about the state of gerontological education. Plonczynski’s team

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2 Earthy (1993) defined gerontologically prepared as faculty who were educated at the master’s or doctorate level in gerontology.
examined the gerontological content and faculty members’ knowledge about and attitudes toward gerontological principles using three instruments for nursing course assessment and faculty needs assessment to provide data for statistical analysis. Their findings suggested that, of the courses that were reported as integrating gerontological content, only 5% of the content in the course was related to older adults. These researchers’ findings suggest that self-reports of integrated gerontological content on the part of faculty and schools should be examined critically.

A recent study of two-year associate degree (AD) nursing programs in the US revealed issues similar to the Bachelor of Science in Nursing (BSN) programs (Ironside et al., 2010). Representatives from 531 of a total of 851 AD programs responded to a survey about their program structure, content, clinical sites, instructional resources, and faculty expertise. Five AD programs were visited and questioned about gerontological content and clinical experiences; focus groups with practicing nurses who had gerontological expertise and were working with new AD graduates were also conducted. Although 85% of respondents indicated they had geriatric nursing content and experiences with older adults integrated in their curricula, the amount of geriatric content per course was (self-) estimated to be between 10 and 25%. Focus groups revealed that having students’ first clinical experiences occurring in nursing homes provided students with a negative impression about caring for older adults. Although the researchers report extensive review and revisions to the survey they developed and used in this study, they neither report the psychometrics of the tool they used, nor do they offer information about their analysis process for their qualitative data, leaving questions about the validity of the reported findings.
2.2.2 Clinical Environments

There is a body of research examining the relationships between knowledge about aging, clinical experiences, and student nurses’ perceptions about older adult care. Two studies offer a glimpse into the varied results. Aud and colleagues (2006) conducted pre and posttests of knowledge about aging and perceptions about aging with 325 students over six semesters, during which students received information about older adult care. Their analyses revealed that, although gerontological nursing care courses succeeded in improving students’ knowledge about older adults, their perceptions toward older adults did not improve. Their findings contrast with those of Flood and Clark’s (2009) study that compared perceptions toward aging between nursing students who had received education about aging and non-nursing students who had not. Using previously validated psychometric scales on knowledge about aging and perceptions about aging, the authors found that nursing students had more knowledge and more positive perceptions toward older adults than the other students. Notwithstanding the study limitations, such as not considering students’ ages or previous experiences with older adults, the findings do suggest that there may be positive links between knowledge about aging and positive perceptions of older people.

Although the studies that have examined the links between knowledge and students’ perceptions about older adults have revealed conflicting evidence, there is consistency in identifying clinical experiences as important to student nurses’ perceptions of older adults (Brown et al., 2008; Holroyd et al., 2009; McLafferty & Morrison, 2004). Brown and colleagues studied 700 student nurses over three and a half years through postal surveys, focus groups, and case studies of clinical experiences. Many of the negative experiences students reported occurred on units that Brown et al. described as “impoverished environments”. These units were
characterized by poor standards of care for older people, often related to inadequate physical environments, poor staffing levels, lack of equipment, and lack of education for unit staff. Other scholars have also identified the influence of clinical environments on student nurses’ perceptions about older adults (Holroyd et al., 2009; McLafferty & Morrison, 2004). In a study of 197 baccalaureate nursing students, those with more negative perceptions had experienced exposure to older adults through medical and surgical clinical rotations, without any overt acknowledgement of older adults’ care needs (Holroyd et al., 2009). Another study that used focus group interviews with 9 RNs and 17 nursing students identified that students were learning about nursing practice in clinical settings where older adults were “patronized and infantilized” (McLafferty & Morrison, 2004, p. 450).

In summary, it is clear that there is an extensive literature examining the education of student nurses about older adult care. This research reveals many challenges and some uncertainty about nurses’ knowledge and perceptions of older adult care upon entering the workforce.

### 2.2.3 Educating Practicing Nurses About Older Adults

The limited focus on older adult care in basic nursing education, along with the increasing numbers of older adults accessing healthcare, has led to a growing recognition of the need to educate practicing nurses about older adults. A variety of educational approaches have been proposed, including models that incorporate exposure to knowledge and practical experiences, and support to continue practices that nurses have learned in formal educational experiences (Farkas, Tennstedt, Haley, & Quinn, 2003; McConnell et al., 2009). One well-funded American organization aiming to improve nurses’ knowledge of older adult care is Nurses Improving Care for Health System Elders (NICHE, 2012). NICHE strives to improve
hospitalized older adults care though education sessions with nurses who serve as geriatric resource nurses on their units, as well as through identifying systems that support nursing practice with an older population (Allen & Close, 2010; Kancelbaum, 2010; Steele, 2010). Unfortunately, NICHE’s influence is not as widespread as the need for improved resources, evidenced by reports of limited success in a variety of efforts aimed at improving nurses’ knowledge about older adult care (Farkas et al., 2003; King, 2004; McConnell et al., 2009); consequently, the efficacy of any one approach is unclear.

Reducing the gap between knowledge of older adult care and nursing practice is a complex issue that is not easily solved (Franklin et al., 2011). A systematic review of interventions aimed at increasing nurses’ use of research reported a paucity of evidence about how nursing knowledge is being incorporated into practice (Thompson, Estabrooks, Scott-Findlay, Moore, & Wallin, 2010). Limited understanding about how nurses in general are drawing on research to enhance their knowledge base makes it difficult to claim success in efforts educating nurses about older adult care. Researchers studying how nurses draw on knowledge in their practice have identified experience and social interactions as key sources of knowledge (Estabrooks, 2003; Estabrooks, 2008; McWilliam et al., 2008). Thus, nurses’ experiences with older adults in their basic education, their clinical experiences, and their social interactions with patients and other healthcare professionals all contribute to what nurses understand about older adults, and how they act on their understanding. Empirical evidence about how social interactions and social dynamics within hospital settings influence nurses’ learning and use of knowledge about hospitalized older adults would reduce speculation about what occurs.
In summary, the research exploring nurses’ knowledge of aging suggests that nurses are graduating with inadequate knowledge and limited experience of the population they are most likely to encounter in their practice. Researchers have suggested that students’ formative clinical experiences providing basic care to older adults, without the necessary knowledge of the complex challenges associated with this population and where poor care is modelled, could be providing student nurses with the impression that older adult care is basic and that caring for them does not require complex knowledge (Aud et al., 2006; Holroyd et al., 2009; Ironside et al., 2010; King, 2004; Xiao et al., 2008). Furthermore, despite growing efforts toward continuing education about older adult care for nurses in practice, it is unclear whether practicing nurses receive the necessary knowledge to care for this older population.

2.3 Perceptions About Aging

Myths and stereotypes about aging contribute to negative perceptions about older adults. This is also known as ageism \(^3\) (Brooklehurst & Laurenson, 2008; Butler, 1969; DiBartolo, 2008; Palmore, 2001; McGarry & Simpson, 2009; Robinson, Popovich, Gustafson, & Fraser, 2003). Many scholars have suggested that negative perceptions about aging are influencing healthcare delivery for older adults; specifically, nurses’ negative perceptions influence their practice with older adults (Bernard, 1998; Chappell et al., 2003; Helmuth, 1995; Hope, 1994; Higgins, Van Der Riet, Slater, & Peek, 2007; Horowitz, Savino, & Krauss, 1999; Koch & Webb, 1995; Lovell, 2006; McGarry & Simpson, 2009; Neville, 2008; Sellman, 2009; Plonczynski et al., 2007). Of the research that has focused on nursing practice in hospitals, there are five compelling studies

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\(^3\) “Ageism reflects a deep seated uneasiness on the part of the young and middle aged—a personal revulsion to and distaste for growing old, disease, disability; and fear of powerlessness, ‘uselessness,’ and death” (Butler, 1969, p. 243). While it has been demonstrated that ageism is not uniquely directed to older adults from younger people (Gabrielle, Jackson, & Mannix, 2008), in this study, I am using the term ageism to refer to negative views toward older adults.
describing negative perceptions held by nurses and suggesting that their perceptions influence their practice with hospitalized older adults (Dahlke & Phinney, 2008; Higgins et al., 2007; Kjorven et al.; McCarthy, 2003; Neville, 2008).

One study examined how nurses’ negative perceptions about older people translated into nursing practice with hospitalized older adults. Higgins and colleagues (2007) conducted a descriptive analysis of nurses’ interviews from a larger study exploring health care workers’ perceptions toward older hospitalized people. Through their analysis, they constructed themes of “marginalization and oppression of the older person” and “stereotyping the older person.” They described examples of how older people are disregarded because requests for action are ignored or delayed, or communication with older people is poor. The findings revealed that nurses often viewed hospitalized older adults as a “waste of time” (Higgins et al., 2007, p. 10) and caring for older people as much more time-consuming than caring for younger people. Nurses’ impatience with older adults was, in part, attributed to hospital time constraints. Although this study offered a frank examination of nurses’ negative perceptions toward hospitalized older adults, it did not offer extensive insights about relationships between hospital settings and nurses’ work or how nurses’ knowledge of aging informs their perceptions of older adults.

In an effort to critically examine discourses on delirium and older people, Neville (2008) conducted a discourse analysis on the charts of older people who had experienced delirium while hospitalized. The author explains how a critical gerontological framework provided the methodological foundations for this study and how it was adhered to during the study. His analysis reveals the language used to describe delirious hospitalized older adults often relegates them to negative positions that he identified as “being old doesn’t matter and a second childhood” (Neville, 2008, p. 465). Delirious older adults were considered “worthless” (Neville,
2008, p. 463). He suggests that decisions about staff allocation are often made on the basis of ageist discourse. This means the younger ill patient is more likely than the older patient to receive care from the most experienced nurse. He also suggests accounts of care provided to delirious older adults are similar to how care of infants would be described, revealing entrenched negative perceptions and practices of society through language. Other scholars have also suggested that infantilized talk directed toward older adults is entrenched in healthcare settings (Nelson, 2005). Neville’s study offers insights into how ageist discourse may impact allocation of resources and communication practices of nurses with hospitalized older adults.

In a more recent Canadian discourse analysis, Kjorven and colleagues (2011) conducted a poststructural analysis of interviews with six nurses to examine the practices that shape nurses’ responses to older adults with postoperative delirium. The authors explained how they enacted their theoretical orientation and how it framed their findings. They identified that the frequent occurrence of postoperative delirium in older adults is construed as normal and a behaviour problem, rather than a physiological problem. The authors suggest that societal ageist perceptions contribute to the normalizing of “confusion” in older adults—the term nurses use to describe older adults’ postoperative delirium. The lack of legitimacy given to postoperative delirium in the aging population contributes to ineffective forms of assessment and inappropriate interventions, which in turn increases nurses’ workloads and enhances their negative stereotypes of older adults. In these ways, the language that nurses use influences how they view their older patients and their nursing practice with older adults.

McCarthy (2003) conducted a grounded theory study exploring the clinical reasoning of 20 nurses who practiced with hospitalized older adults. Through dimensional analysis, she developed a theory suggesting nurses ascribed to one of three distinct perspectives that influence
how they focus their observations, decisions, and management of their older patients. McCarthy suggests that, if nurses subscribe to a *decline* perspective, they are less likely to make distinctions between acute and chronic changes in the older adults and to respond to symptoms of a medical emergency, such as delirium. They are also more likely to believe that death and decline are normal and expected with hospitalized older adults. If nurses subscribe to a *vulnerable* perspective, they are likely to believe that disease and decline among older adults are not inevitable, but likely. They are also more likely to assess and intervene with delirious older patients if they receive social support from their peers and/or administrators and their workload permits. Nurses who subscribe to a *healthful* perspective of older adults view them as essentially well and are more likely to detect problems and intervene if an older adult exhibits signs of acute illnesses. This study offers valuable insights into a range of nursing perspectives and how they might influence nurses’ practice with hospitalized older adults. Unfortunately, evidence about the rigour of this study is limited and information about how nurses’ knowledge of aging or institutional settings contribute to nurses’ perspectives of aging is lacking. Limitations notwithstanding, the theory offers understanding about how perspectives about aging might be influencing nursing practice.

Finally, I examined how nurses care for hospitalized older adults at risk for delirium (Dahlke & Phinney, 2008). My content and thematic analysis revealed that nurses often feel frustration trying to care for an aging population in a system that is not designed for managing the complex needs associated with both acute and multiple chronic conditions. Negative societal perceptions about older adults are perpetuated in nurses’ statements such as “they’re old, they’re confused…it’s just time-consuming and not fun to deal with” (Dahlke & Phinney, 2008, p. 45). This study, like the others addressed above, raises questions about the complexity of nursing
practice with hospitalized older adults, especially in the context of negative personal and societal perceptions about aging and how those perceptions are shaped by knowledge and institutional systems.

2.4 Institutional Systems of Care

While there is evidence within the literature identifying nurses practicing with hospitalized older adults as frequently holding negative perceptions about these older people, nurses’ perceptions about older adults and their practices with an older population are also influenced by work environments that are often chaotic, with systems of care that are not suited for older people and allocation of resources that reinforce ageist views (Chappell & Penning, 2001; Clarke, 2006; Haught, Christ, & Dias, 1994; Helmuth, 1995; Higgins et al., 2007; King, 2004; Lookinland & Anson, 1995; Lovell, 2006; McLafferty & Morrison, 2004; Peek et al., 2007; Rodney & Varcoe, 2012; Sellman, 2009; Wakefield & Holman, 2007). Researchers also suggest that the contexts in which nurses work influence their capacity to exercise autonomous decisions regarding the care of their patients (Musto & Schreiber, 2012; Newton et al., 2012; Peter & Liaschenko, 2004; Rodney et al., 2013).

Scholars have identified that older adults require different modes of care delivery than those supported by prevailing models (Chappell et al., 2003; Peek et al., 2007). Since the late 1970s, a variety of methods of delivering care to older adults within acute hospital settings has been developed (Capezuti & Brush, 2009). These initiatives commonly focus on approaching care of older adults through a bio-psychosocial model with intent to enhance and maintain older adults’ function (Capezuti & Brush, 2009; Covinsky et al., 1998; Flaherty et al., 2003; Inouye, Bogardus, Baker, Leo-Summer, & Cooney, 2000; Parke & Brand, 2004). Evidence supports the use of these specialized models of care as an intervention to improve outcomes of hospitalized
older adults (Baztan et al., 2009; Hickman et al., 2007; Walsh & Bruza, 2007); however, research about these specialized models has focused on patient outcomes, without specifically examined nursing practice, (Hickman et al., 2007) or issues that influence nurses’ enactment of their practice with hospitalized older adults. In the following section, I will examine the literature illuminating nurses’ perceptions of healthcare institutions and how healthcare institutions are influencing nurses’ perceptions of their practice.

2.4.1 Nurses’ Perceptions of Institutions

A growing number of researchers have examined acute care practice environments and nurses’ perceptions about the influence of these environments on their practice with older adults (Boltz et al., 2008; Cheek & Gibson, 2003; Kim, Capezuti, Boltz, & Fairchild, 2009; McKenzie et al., 2011). Cheek and Gibson conducted a descriptive, exploratory study using mixed-methods to identify issues that affect the provision of nursing care to hospitalized older adults. These methods included critical incident technique, interviews, focus groups and nominal groups. They identified three themes from their analysis: the complexity of managing the healthcare needs of the older person with an acute illness; the acute care environment as a problem for managing the older person; and the difficulties of maintaining continuity of care in a fragmented and under-resourced healthcare system. As an element of these themes, they suggest registered nurses (RNs) have a pivotal role in managing the care of hospitalized older adults. At the same time, they argue that RNs frequently lack the knowledge, staffing resources, and status within their organizations to effectively manage their care. Moreover, the institutional emphasis on managing acute illness episodes does not match the needs of older adults. While this study offers insights into nursing practice with hospitalized older adults, the contribution of multiple data collection methods to the authors’ conclusions was not presented, thus leaving unanswered questions about
the rigour of the analysis. Moreover, this study did not include observations of nursing practice that could have enhanced the validity of nurses’ reports of their practice as representing their actions.

Boltz and colleagues (2008) described nurses’ perceptions about supports within their acute care environments. This work has been further developed both in the United States (Kim et al., 2009) and Canada (McKenzie et al., 2011). Boltz and colleagues conducted a secondary descriptive analysis of data from the Geriatric Institutional Assessment Profile of 75 American hospitals to examine nurses’ perceptions of support for geriatric care in their respective institutions. This study used linear mixed-effects modelling to explore associations between quality of geriatric care and factors such as nurse staffing, hospital characteristics, and geriatric nursing knowledge. They reported a significant relationship between positive institutional values for geriatric nurse practice and the quality of geriatric care. Moreover, positive institutional valuing of both older adults and staff had a significantly positive relationship with nursing knowledge. They also reported that working in a setting that supports nursing practice with hospitalized older adults improves nurses’ perceptions of support and their perceptions about quality of geriatric care but does not necessarily improve their knowledge of aging. Although this study offers some useful information about the importance of positive values for supporting older adults within institutions and nursing practice, it has several limitations. Most notably, the study relies on nurses’ self-reports of support and quality of geriatric care; however, the authors do not identify what nurses perceive as supportive. Moreover, nurses’ self-reports of what is quality geriatric care and geriatric knowledge was accepted at face value and not further explored.

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4 Boltz et al. (2008) measured geriatric nursing knowledge by “measuring nurses’ knowledge of restraint use, incontinence, sleep, and pressure ulcers” (p. 285).
Kim and colleagues (2009) conducted a secondary analysis of the same data Boltz and colleagues (2008) used to examine the relationship between the nurse practice environment (NPE) and nurse-perceived quality of geriatric care in hospitals. They examined responses of 192 nurses who worked in three non-profit acute care hospitals in New York State. Based on regression analyses, these scholars suggested that more favourable perceptions of geriatric-specific NPE and nurses’ participation in hospital affairs are associated with nurses’ higher perceptions of quality of geriatric care. In other words, nurses believe they can provide high-quality geriatric care in hospitals where the needs of older adult patients are valued, there is institutional support for the healthcare team to collaborate, and geriatric resources are available. As with the previous study, these researchers accept nurses’ perceptions about quality geriatric care without any exploration of what might be considered quality care from nurses, patients, and other points of view.

McKenzie and colleagues (2011) compared nurses’ perceptions of geriatric care environments in three Canadian hospitals. They surveyed 1,189 nurses using the Geriatric Institutional Assessment Profile, an instrument used in previous studies (Boltz et al., 2008; Kim et al., 2009). They used one-way analysis of variance (ANOVA) to compare nurses’ scores. They reported nurses’ perceptions of a positive geriatric practice environment that aids in delivering aging-sensitive care varies by the type of hospital, with nurses from geriatric chronic care hospitals reporting the most positive perceptions followed by nurses in tertiary and community hospitals. Similar to the two previously mentioned studies (Boltz et al., 2008; Kim et al., 2009), nurses’ self-reports of quality geriatric care were not interrogated in terms of what constitutes this type of care. The researchers suggested that there is considerable room for improvement in providing both optimal care environments and aging-sensitive care based on their data of nurses’
perceptions either clustered around the midpoint of the scales or slightly toward the positive end of the measure. However, their suggestions for improvements were made without any reported relationships between these two areas. The small body of research examining nurses’ perceptions of caring for hospitalized older adults offers useful insights; however, many questions remain about how nurses’ perceptions of support influence their daily practice with hospitalized older adults, and the interaction between workplace settings and nursing practice. Moreover, what nurses perceive as quality geriatric care also remains elusive.

2.4.2 Nurses’ Perceptions of Their Practice

Cost-containment strategies that have accompanied the healthcare reforms of the 1990s have resulted in increases to nurses’ workloads (Campbell, 1994; Carson & Ross, 2000; Chappell et al., 2003; Clarke, 2006; Heartfield, 2006; Rachlis, 2004), leading nurses to focus on being efficient, despite the negative consequences to both nurses and their patients (Rodney & Varcoe, 2012). Research has shown that nurses experience distress when their “moral choices and actions are thwarted by constraints” (Austin et al., 2003, p. 177). In a survey conducted by the Canadian Nurses Association (CNA) and Canadian Healthcare Manager, nurses reported that they lacked time to adequately do their jobs, which often resulted in moral distress when they could not complete even basic care for their patients (Goveia, 2009). Other studies have shown that, within the context of an increased workload and concerns about patient safety, nurses come to rely more on physically and chemically restraining their older adult patients (Ashley, 2008; Dahlke & Phinney, 2008; Inouye, Brown, Tinetti, 2009), despite their feelings of regret when such actions are not in keeping with nurses’ values about patients’ autonomy and quality of life (Pavlish, Brown-Saltzman, Hersh, Shirk, & Rounkle, 2011; Rodney & Varcoe, 2012).
Scholars have suggested that there are complex relationships between nurses’ perceptions about the need to be efficient and their practice. Drawing on findings from a series of studies, Rodney and Varcoe (2012) explain how perceptions regarding corporatism and the scarcity of resources (especially time) are contributing to nurses organizing their work to achieve greater efficiency. These authors further suggest that nurses’ focus on efficiencies in their work routines causes them to experience feelings of guilt and fatigue when they do not have the time to attend to patients’ nonphysical needs and, at times, even the most basic physical needs. Rodney and Varcoe also explicate how nurses ration their time by making the most acute patients a priority and use social judgments based on factors such as age to guide the amount of care an individual should receive.

Austin (2007) also offers a useful analysis of how healthcare values and institutional systems of care challenge nurses’ practice. She suggests that the focus of “doing more and faster” (Austin, 2007, p. 84) predominates in healthcare environments, and this is influencing nurses’ practice in negative ways. Her recommendation that nurses openly discuss their practice concerns points to the important role that nurses play in influencing their practice and the care of their patients. Unfortunately, a recent survey of 6,000 RNs practicing in British Columbia (BC) suggests that nurses may not be speaking up about their practice concerns (Newton et al., 2012). These authors have suggested that workplace environments that do not encourage or validate nurses’ concerns are effectively silencing nurses. They have also suggested that nurses may not be speaking up as a means of protecting themselves in an environment they view as unresponsive to practice concerns.

Rodney and colleagues (2013) have offered further contributions to the ongoing dialogue about nurses’ roles in the decisions that influence the care of patients. They argue that nurses
exercise moral agency through their relationships with patients and other healthcare professionals, but are constrained by the healthcare institutions where they work. Rodney and colleagues identify factors such as age, gender, social and historical relationships (such as having moral concerns examined through a dominant male perspective) as well as wider social structures, that together influence how nurses perceive their moral agency, their interactions with others, and how they make decisions about patient care situations. Although Rodney and colleagues do not specifically identify older adult care as problematic for nurses in exercising their moral agency, they do explain that nurses frequently feel constrained in their clinical decision-making and that social factors such as age influence how nurses exercise their agency. Taken together, the evidence suggests that complex relationships between workplace environments and nurses’ participation in their practice challenges have the potential to contribute to negative outcomes for older patients. These complex relationships also contribute to how nurses articulate their practice challenges.

In summary, many scholars have identified effects of hospital systems on nurses’ ability to provide care (Austin, 2007; Boltz et al., 2008; Cheek & Gibson, 2003; Dahlke & Phinney, 2008; Goveia, 2009; Higgins et al., 2007; Institute of Medicine [IOM], 2004; Kim et al., 2009; McKenzie et al., 2011; Peek et al., 2007; Rodney & Varcoe, 2012; Sellman, 2009; Wakefield & Holman, 2007). Moreover, the relationship between workplace environments and how nurses are engaging in their practice is very complex (Austin, 2007; Goveia, 2009; Newton et al., 2012; Pavlish et al., 2011; Rodney & Varcoe, 2012; Rodney et al., 2013). A clear picture of how nursing practice with hospitalized older adults is enacted in the context in these complex systems remains elusive, but is necessary to enlighten healthcare providers and policymakers about potential outcomes for nurses and hospitalized older adults.
2.5 Summary

In this chapter, I have critically analysed the literature examining the key contextual issues related to nursing care of hospitalized older adults. My discussion of the findings from this empirical work offers some insights into nursing practice with hospitalized older adults. In general, nurses’ knowledge about older adult care is regarded as insufficient, negative beliefs about aging are documented in hospital settings, and the systems within healthcare institutions frequently do not support care of hospitalized older adults. Evidence also supports the claim that nursing practice with hospitalized older adults is fraught with many challenges. Nonetheless, how nurses enact their practice in the context of the challenges is not well understood. Further research is necessary to support nursing practice with an older population; thus, it is important to examine how nurses’ perceive and enact their practice with hospitalized older adults.
CHAPTER THREE: THEORETICAL FRAMEWORK

3.1 Introduction

In this chapter I describe how symbolic interactionism (SI) provides a theoretical framework for my study of nurses’ practice with hospitalized older adults. I emphasize SI as defined by Mead (1934) and Blumer (1969), drawing on specific theoretical points related to SI from other scholars. An SI theoretical perspective provides an interactional framework that is pivotal to my understanding of how nurses engage with others within hospitals to make meaning of their practice and how their meaning-making can influence their decisions regarding care of older adults. My description of SI occurs in three parts. The first part is an overview of SI, wherein I provide information about the history, ontology, and epistemology for SI and an explanation of why SI is appropriate for this study. In the second part, I explore the key concepts of SI. Finally, in the last section, I explain how SI guides this study methodologically.

3.2 Overview of Symbolic Interactionism

Mead (1934) is recognized as the originator of SI. He offered insights about how human beings develop selves, consciousness, and complex actions as a result of their interactions and associations with one another. The human actor is constantly making meaning of self, objects, and others in the social world (Mead, 1934). He or she acts based on what is wanted, developing goals to achieve desires and mapping out prospective lines of behaviour (Mead, 1934). Blumer (1969) is credited with developing many of Mead’s ideas (Charon, 1985). Both Mead and Blumer were influenced by Dewey’s (1925/1998) perspective of pragmatism. Kadlec (2007) highlighted how SI reflects Dewey’s beliefs that all knowledge is relational and that dynamic contextual relationships affect how individuals construct meaning.
Mead (1934) claimed that human consciousness aids people in analysing their responses and the responses of others to gain an understanding of themselves, others, and the world around them. Human thinking about the self and the world around them is only possible through symbols (Mead, 1934). Thus, SI holds that there is a reality that can be apprehended (ontology) but objects are symbolized through the orientations and actions of people toward them and interactions among people (Blumer, 1969; Mead, 1934). Reality, represented by the meaning of objects, is created through “the conjoint activities of several minds” (Perinbanayagam, 1985, p. 17). Meaning that emerges is interpersonal. Based on a social constructionist epistemology, SI represents knowledge about reality as constructed in interactions among human beings and their social world (Mead, 1934). A social constructionist epistemology is well suited to this study because nursing practice is enacted through relationships in which nurses are constructing meaning about older adults and particular patient care contexts based on their actions with one another, their patients, and other healthcare team members.

SI is predicated on four central ideas articulated by Blumer (1969). Firstly, people individually and collectively act on the basis of the meanings they assign to objects that comprise their world. Secondly, people engage in a social process of making indications to one another and interpreting each other’s indications. Thirdly, social acts, whether individual or collective, are constructed through a process in which the actors note, interpret, and assess social acts and fit together their acts to form joint acts. Fourthly, lines of action, which individuals interpret and that occur in patterns within institutions, reflect divisions of labour and networks of interdependency that are dynamic and changing.

The central ideas for SI articulated by Blumer (1969) are well suited to the study of nursing practice because of the need for nurses to be in relationships with patients, their families,
and other healthcare providers. Nurses are thinking critically about their observations and interactions with others and framing these observations and interactions within nurses’ perceptions of the care context and available resources (Litchfield & Jonsdottir, 2008). This need within nursing to be in relationships and to be constantly interpreting and developing lines of action is well accounted for within the central ideas of SI.

Human group life consists of people communicating (verbally and nonverbally) and people acting based on the meaning they attribute to objects (Blumer, 1969). The shared meanings, provided through language, make language one of the most important symbols in human group life. Objects are not only physical items (such as charts or medications) but may also be social roles (such as doctor or nurse), or abstract principles (such as caring or aging). The social world can only be known through the perspectives of the people within the social world who are acting based on the meanings they have derived from interactions with others and objects (Blumer, 1969; Mead, 1934). The linking of lines of action to form joint lines of action occurs in social organizations through complex interdependent relationships (Blumer, 1969). The ideas from SI about human group life are helpful in examining nursing practice in hospitals where nurses are working with healthcare professionals, as well as patients (and their families), all of whom have a wide variety of social characteristics and bring meaning attributed to objects that is derived from interactions with others and objects.

Symbolic interactionism provides a theoretical framework to guide exploration into meaning-making that occurs as the individual acts toward others, or symbolizes objects and shared beliefs that are present in social environments. It is a framework that stresses the connections between symbols (known as shared meanings) and interactions, both through verbal and nonverbal communication (LaRossa & Reitzes, 1993), which ultimately inform human
group life (Blumer, 1969). Since nursing practice is influenced both by the relationships with individuals in nurses’ care and other healthcare providers, as well as the social environments in which nurses work, SI is an appropriate framework to guide inquiry into the complex social issues of nursing practice with hospitalized older adults. Blumer’s view of human actors defining and redefining complex interconnected relationships in order to deal with problems is well suited to a study of nurses who must consider how they symbolize objects and interactions and develop their lines of action, within the complex interrelated relationships of an acute care hospital setting.

3.3 Major Concepts of Symbolic Interactionism

In order to gain a full understanding of how SI provides a theoretical framework for the study of nursing practice with hospitalized older adults, it is important for me to examine the major concepts of SI. These major concepts include: self, objects, social interaction, meaning, language, and society.

3.3.1 Self

The self is developed through social interactions with other people who help in defining the individual (Mead, 1934). Social processes and interactions that occur from birth through adult life aid in developing the self. Humans organize their experiences and their memories through the self, which is often initially shaped by social experiences within the family as the basic unit of social organization where vital activities and functions are perpetuated (Mead, 1934). Because families are located within larger social organizations of communities and society, the self is also developed through the standpoints of others in the same social group (Perinbanayagam, 1985), whether it is the family unit, the nursing profession, or Canadian society. In the case of this study, the concept of the self encouraged me to recognize that nurses’
beliefs about themselves and aging have developed through their experiences in their families, basic nursing education, past work experiences, and experiences as members of society. The concept of self, as part of past experiences and values, yet dynamic and under construction in current experiences, helped me to understand how nurses are perceiving themselves through the constant evolution of their ideas about who they are as people and as nurses.

As conscious beings, humans have an ability to view the self from objective and subjective standpoints (Mead, 1934). Mead refers to this ability as “I” (the personal self) and “me” (the self in social situations). This means that people have a concept both of their personal and social selves. Self-consciousness is only possible because of the social me and I; having a self allows humans to interact with themselves (Blumer, 1969). People have the ability to reflect on the self, and through this reflection to adjust their thinking and further actions. Individuals’ knowledge of their internal selves is derived from their knowledge and reasoning about the external world (Perinbanayagam, 1985). Before humans act, they confront themselves within the social world, confront the social world, and interpret both (Blumer, 1969). In this way, individuals are able to evaluate their actions and the actions of others. Blumer argues that this information can then be used to adapt further actions and can be remembered for similar future situations.

The concept of self informed my analysis of how nurses process and make meaning of their work circumstances. This concept provided a useful lens for examining the dynamic changes in nurses’ thinking and in their actions. An important part of nursing practice is evaluating nurses’ actions, both their own and those of others. The idea of a personal self and a social self was a useful way of thinking about the nature of nursing actions as dynamic, within relationships and contexts (Doane & Varcoe, 2007; Litchfield & Jonsdottir, 2008).
3.3.2 Objects

The nature of the social world is based on the meaning that its constitutive objects have for human beings (Blumer, 1969). Objects exist in three categories: physical, social, and abstract. Physical objects in a nurse’s social world include items that are physically present, such as beds or thermometers. Social objects include roles of nurses or other actors within the social world. Abstract objects are ideas or concepts, such as comfort or safety, which nurses may regard as meaningful to their practice. All objects are social products with meanings that are formed and transformed through the process of social interactions in social worlds; the meaning of objects arises through these interactions and agreement and disagreement about meaning with others within the social world (Mead, 1934).

In my study, the concept of objects aided in exploring the complexity of nurses’ meanings in their practice with hospitalized older adults. Some scholars have suggested that nurses’ perceptions of gerontological care are influenced by organizational structures (Boltz et al., 2008), which are a type of object. I found that conceptualizing objects in this way helped me to explore how nurses interpreted particular physical, social, and abstract objects as they enacted their practice with an older population. Nurses’ interpretations of these objects influenced them as they developed their lines of action for gerontological care. Furthermore, paying attention to how nurses took up or resisted social objects, in the social context of acute hospitals, offered me some useful insights into their complex practice.

3.3.3 Social Interaction

Social interactions influence the meanings people assign to objects and how they act toward objects (Blumer, 1969). Individuals develop their thinking and actions in the context of social processes, which offer opportunities for individuals to define and redefine their lines of
action (Blumer, 1969). Thus, individuals interacting through social processes can begin to share similar or different meanings of situations and objects.

People are able to analyse what to do using intelligence developed from social processes (Mead, 1934). Individuals’ ideas of how people “ought” to behave are developed from integrating and resisting patterns of organized social behaviour (Mead, 1934). Through interaction and exchange, an event, an object, or an idea is constructed (Hollander & Gordon, 2006). People construct objects differently, which can lead to social change when they are resistant to particular social constructions of these objects.

For my study, the concept of social interaction was useful to examine how nurses interpreted nursing practice, both individually and in groups. The importance of social interactions sensitized me to examine how nurses interpreted the behaviour of their older adult patients, and to examine how social interactions with other nurses, as well as with patients, families, and other healthcare professionals influenced how they made meaning of behaviour. The possibility that social interactions could influence nurses as they developed their lines of action drew my attention to social processes and shared meanings in nurses’ practice. Moreover, this concept sensitized me to be aware of situations when nurses were developing their lines of action to conform to how they believed they should practice, where nurses were resisting practicing the way they believed they should, and situations where nurses varied in their approaches to constructing their practice. Nurses’ resistance offered the opportunity to create space for shifting constructions of social ideas about how they believed they should be practicing. In these ways, nurses were actively creating and recreating their world and their lines of action.
3.3.4 Language

Mead (1934) identified language as essential to the development of the self. It is through language that social meanings are co-created and larger ideas that reflect society’s values are transmitted (Hollander & Gordon, 2006). Language is the most complex “set of consensual meanings that offer the possibility of communication and affirming the shared meanings of the physical world and the social world of norms, values and roles” (LaRossa & Reitzes, 1993, p. 1). Context, such as that of a hospital environment, is central to the process of constructing meaning through language (Hollander & Gordon, 2006). Language enables individuals who are engaged in cooperative activities to understand, respond, and influence one another (Mead, 1934).

In my study, the concept of language sensitized me to pay attention to and examine words that nurses frequently used to explain their work or to support their lines of action. The importance of language, both in an individual nurse’s development and in the development of common understandings among nurses, invited me to ask clarifying questions and to enquire about individuals’ origins and how they may have shaped their perspectives, as well as how hospital structures could constrain lines of action and change language.

3.3.5 Meaning

Meaning-making occurs in the process of interaction between people (Blumer, 1969; Charon, 1985). As such, meanings are social products. Language and communication are fundamental to the development of meaning within the minds of individuals, although communication is part of meaning-making within the social environment through the processes of social activity (Mead, 1934). People respond to each other during their interactions, and they interpret their interactions through shared meanings associated with objects and symbols (Blumer, 1969). Meanings are modified by the interpretation of the people dealing with objects.
Individuals also interact with themselves to make meanings and develop lines of action based on those meanings (Blumer, 1969). Mead’s (1934) idea of the “I” and the “me” offered me a way to understand how individuals examine their social selves in the process of acting (through the “I”) and examine their thinking about an act (through the “me”). It is through this internal communication and ability to reflect that humans engage in processes of interpreting their engagement in social interactions, make meaning of social processes, and choose how to act in particular situations.

In my study, my theoretical framework invited me to assess how nurses made meaning of their practice with hospitalized older adults and their choices about how to act in acute hospital settings. Specifically, I inquired about nurses’ perceptions of older patients’ behaviours, their interactions with other team members, and how those interactions might be influencing their perceptions. Nurses’ responses were useful in developing an understanding about how they symbolized older adults and developed their lines of action in response. This inquiry provided me with insights into how nurses were engaging in activities that were meaningful for the social groups on their nursing units, and how they developed their perceptions about their engagement in these social activities.

3.3.6 Society

Society is a general social environment, comprised of complex social interrelations and interactions (Mead, 1934). Individuals are dependent on the familiarity of society, regardless of whether the social environment is stable or unstable (Mead, 1934). There would not be society without individuals who have minds and selves (Mead, 1934). Symbolic interactionism attends to both societal constraints and individuals’ freedom. Individuals are influenced by social beliefs and values through social interactions (Mead, 1934); moreover, differencing power structures can
affect how free individuals feel to develop their lines of action by resisting social beliefs and values (Peribanayagam, 1985). Through interactions with groups, individuals can express their agency by influencing and even changing the beliefs and values of a group. Because social interactions are dynamic and continuous, society is changed by this process.

Society consists of many individuals interacting in a process that forms lines of human action (Mead, 1934). It is only in action that human groups or societies can be appreciated. Joint or collective lines of action are developed during processes of interpretative interactions among many people (Blumer, 1969).

In my study, the idea of joint lines of action in the context of Canadian society sensitized me to look for situations where participants were collectively influenced in developing their lines of actions to manage a particular situation by expressing their agency. This idea also guided me to examine how participants’ values were influenced by symbolization and interactions with others in order to act through joint lines of action. Blumer’s (1969) idea that in stressful situations, people may develop new joint lines of action that are part of the continuity of previous actions, guided my examination of how nurses responded in crisis situations and how their responses might have been similar or different from their usual ways of responding to their practice. The ideas of society and joint action served as useful concepts to explore how nurses symbolize older adults and care of older adults. They do this in the context of complex layers of influence from institutional settings and society in general as they enact their practice with older hospitalized adults. These ideas encouraged me to attend to how perceptions about older adults within society influenced nurses as they practiced as part of a nursing team within hospitals. It also suggested that attending to how nurses participate in care practices within hospitals could illuminate values within nursing and within society.
3.4 Methodological Implications

The methodological implications of SI will be discussed first in general terms, and then in relation to this study. Next, how the literature review and SI invited further examination of the issues related to nursing practice with hospitalized older adults will be discussed. Finally, the research purpose and questions of the study are provided.

Hall (1987) asserts that SI assumes that dynamic human action requires a sceptical, curious and empirical orientation toward the social world. Blumer (1969) has suggested a number of methodological considerations associated with SI. As a guiding theoretical framework, one of the methodological implications is a direct examination of social action within the social world in order to highlight problems in that world (Blumer, 1969). Social action must be studied in terms of how it is formed over time (Blumer, 1969; Hall, 1987) and through naturalistic investigation of the actual group life of the actors as they engage in complex, interrelated activities (Blumer, 1969). Examination of social worlds requires both close observation and awareness that the actors are contributing to the collective social world from differing reference groups (Blumer, 1969). It also requires seeking an understanding of how the actors (in this study, the nurses) are symbolizing the objects around which they are acting (Blumer, 1969).

Although some scholars have criticized SI for a lack of attention to influences of macro social structures, such as imbalances of power, other scholars have argued that how language is constructed (Hollander & Gordon, 2006; Perinbanayagam, 1985) and the symbolic meanings that are attached to objects in everyday situations can represent macro issues (Dennis & Martin, 2005). Hall (1987) suggests that, through examination of everyday social worlds, insights can be gained about how conventions and constraints of political and economic contexts are perpetuated.
or resisted. This line of thinking implies that through my investigation I could examine how nurses’ everyday social worlds are influenced by and provide insights into larger contexts and how nurses affect their everyday social worlds.

Nurses from different age groups, sociocultural backgrounds, and families of origin are all a part of the social world of an acute care hospital unit. Thus, individuals’ backgrounds, ages, and cultures are reference groups that influence how nurses make meaning of their social world and their collective nursing practice. Using SI directs me to consider the ways that my background, my use of language, and my presence influenced nurses’ meaning-making and their symbolization of objects that occurred during my interactions with nurses and others on the units during this study. Using SI as a sensitizing theoretical framework also directed me to pay attention to the naturalistic environment and the factors that human actors within these everyday social worlds indicated were important in their meaning-making. Within these social worlds, SI directed me to examine networks of interdependency among the nurses, how nurses were making indications of self-consciousness, the objects they symbolized, and how they acted around these objects. It directed my attention to the possibility that the everyday social worlds explicated through language, nurses’ meaning-making, and their lines of action could be representing larger issues within the hospital, healthcare, or Canadian society.

Using SI has the methodological requirement to explore and inspect (Blumer, 1969; Weigert, 2008). SI describes an active process for examining how people develop a concept of self and others through their interactions, and how these interactions provide people with opportunities to decide how to behave (Blumer, 1969), making it well suited to using a naturalistic qualitative research method that directs the researcher to examine complex social processes (Glaser & Strauss, 1969). Moreover, within SI inspection and analysis can be
strengthened by comparative analysis of contexts (Hall, 1987). To complement the comparative analysis aspects of SI, I used the research method of grounded theory (GT), which has the essential elements of concurrent data collection and analysis, and constant comparison (Glaser & Strauss, 1967). In GT, data analysis and data collection occur simultaneously to provide the opportunity to develop a theory that is situated in the data (Glaser & Strauss, 1967; Glaser, 2001). By constantly comparing incidents, categories, and their properties, a theory can be developed that has a broad range of incidents with minimal concepts (Glaser & Strauss, 1967; Glaser, 2001). GT methods also provide the opportunity for concepts related to power inequities and larger contexts to earn their way into the theory when theory construction reveals them to be important concepts related to what is happening in the social world and what participants believe is important.

3.4.1 Overview of Literature Review and Theoretical Framework

Both the literature review and the theoretical framework for this study bring to the fore issues related to nursing practice with hospitalized older adults; they invite further examination of this area. My review of the literature in Chapter Two identified how nursing practice with hospitalized older adults is challenging due to nurses’ limited knowledge base, negative perceptions of aging, and institutional contexts that are not designed to meet the needs of an aging population. The paucity of information about the role that nurses play both in influencing their workplace settings and their patients’ care has occurred as a result of minimal research examining nurses’ work with hospitalized older adults from the perspective of nurses themselves.

The theoretical perspective of SI guided me to pay close attention to what was going on in the social world within hospitals and how nurses were making meaning of their practice with
older adults within this social context. This perspective encouraged inspection of how nurses were influencing the social context of their work environment and the care of hospitalized older adults. My theoretical framework and review of the literature review inform the purpose of my study.

3.4.2 Study Purpose and Research Questions

The overall purpose of my study was to explain nurses’ practice with hospitalized older adults. The research questions were constructed to examine how nurses make meaning of their work with older adults in order to explain their practice in the complex social world of hospitals. While other groups such as patients, families, and other healthcare disciplines, also have perspectives about nursing practice with hospitalized older adults, my study examines the perspective of nurses. The research questions include:

1. How do nurses enact nursing practice with hospitalized older adults?
2. What facilitates nursing practice with hospitalized older adults?
3. What constrains nursing practice with hospitalized older adults?

3.5 Summary

In this chapter, I have presented the key elements of SI in relation to how this theoretical framework has been useful in guiding my study. I have identified how it was used to develop the research questions. How I accomplished the study will be explained in the following chapter describing the research methods.
CHAPTER FOUR: STUDY METHODS

4.1 Introduction

This study was based on a grounded theory (GT) design guided by symbolic interactionism (SI). GT was used because it provided an opportunity to explain an area of nursing practice that is poorly understood. Symbolic interactionism provided theoretical guidance for this study by informing the research questions, data collection, and data analysis. GT is useful for studying nursing practice with hospitalized older adults because it is well suited for investigating complex human processes (Glaser & Strauss, 1967; Glaser, 2001). The GT approach involves inductively developing a theory from data about a phenomenon (Glaser & Strauss, 1967). It is partially based on some of the theoretical tenets of SI (Burns & Grove, 1997). A GT study guided by SI focuses on how participants co-create meaning and construct and interpret behaviours; such an approach is important for the study of nursing practice with hospitalized older adults in the context of a socially constructed healthcare system.

This chapter includes an overview of the method and descriptions of the research settings and sample, ethical considerations, and research procedures. Research procedures include how the sample was recruited, data collection processes, data analysis, and how criteria for rigour were addressed.

4.2 Overview of Grounded Theory

GT was chosen as the strategy of inquiry for this study because it offers a systematic and rigorous approach to examining complex human processes (Glaser & Strauss, 1967; Glaser, 2001), and seeks to explain how participants are managing a problem that is central to them (Glaser, 1992; 2001). Researchers use GT to generate a substantive midrange theory of novel
concepts and relationships among the concepts that are grounded in the data (Glaser & Strauss, 1967; Glaser, 2001). Data collection in GT can include interviews, observational data, and existing documents; in short, everything may be considered data (Glaser, 1992; 2001). It is the conceptualization of data at a theoretical level that is a goal of GT (Glaser, 1978; 2001). When generating theories, Glaser and Strauss encourage researchers to attend to incidents in the data and their contributions to theory development, and decide about the need to sample for further incidents and to develop categories. The researcher’s ideas about what questions to ask and the incidents that are necessary to inform theory development are guided by categories developed during analysis. In this way, the theory that is developed can be abstract and yet grounded in the data; it is a representation of the phenomenon of concern to participants. Being guided by SI also directs the researcher to examine how meaning-making is constructed between the researcher and participants about the problem that participants are working to resolve in their social world.

The original approach to GT emphasizes the need for categories to earn their way into the theory through the data, as opposed to forcing data into researchers’ preconceived frameworks (Boychuck Duchscher & Morgan, 2004; Cutcliffe, 2005; Glaser, 1978, 1992; 2001; Walker & Myrick, 2006). Many versions of GT that have developed since the original method have been criticized for being overly formulaic and programmatic (Boychuck Duchscher & Morgan; Cutcliffe, 2005; Glaser, 1978, 1992; 2001; Walker & Myrick, 2006). For this study, I followed the Glaserian interpretation of the original GT method, which includes the elements of concurrent data collection and data analysis, theoretical sensitivity, use of constant comparison, theoretical sampling, and extensive memo writing (Glaser & Strauss, 1967). Glaserian GT is designed to allow flexibility because the research question is loosely formulated, allowing for alterations of the questions the researcher is asking participants in order to generate data that is
germane to the problem participants are processing and theory development (Glaser, 2001; Simmons, 2011).

4.3 Research Settings

The settings for this study were two acute care hospital units where most patients were older adults\(^5\) (defined in both settings as \(\geq 65\) years). The units included a specialty geriatric unit in a large teaching hospital and a general medical unit in a smaller community teaching hospital. Both hospitals were publicly funded by a provincial government, but were under the administrative direction of different regional health authorities. As a sensitizing framework, SI encourages the researcher to examine how variation in contexts influences participants’ meaning-making. Thus, I chose two study sites that could offer both commonalities and differences in terms of their contexts. This provided greater opportunity to sample theoretically from incidents within the data as a way to enhance theory development.

4.4 Study Sample and Sampling

In GT, small sample sizes provide the opportunity for increasing the in-depth exploration of the research questions (Glaser, 1978; 2001). Prior to beginning data collection, I anticipated a sample of approximately 20 participants. This number was based on sample sizes described by other researchers and what seemed to me to be realistic for a study of this scope. Nonetheless, sample size is ultimately determined when the researcher has sampled enough incidents from participants to develop a theory that is theoretically complete, accounting for as much variation with as few concepts as possible (Glaser, 1978, 1992; 2001). After 24 participants, I deemed I had sampled enough incidents to provide extensive variation; moreover, I identified no incidents that enhanced my development of the theory.

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\(^5\) Older adults have been defined as aged 65 years or older (World Health Organization, 2013).
Symbolic interactionism provided me with guidance about the importance of attending to naturalistic settings by observing and examining how all members of the nursing care team created meaning about their care of older adults within their hospital units. Therefore, it became necessary for full theoretical development to sample for incidents within all members of the nursing care team, including registered nurses (RNs), licensed practical nurses (LPNs) and patient care aides (PCAs). Nurses are defined as care providers who are registered or licensed by a regulatory body (Canadian Nurses Association [CNA], 2012). RNs’ scope of practice includes caring or directing the care of stable and unstable populations and LPNs’ scope of practice includes caring or directing the care of stable populations. I included PCAs (who are unregulated care providers and work under the direction of RNs and LPNs) because their perspectives aided in sampling incidents about how the nurses (RNs and LPNs) symbolized and acted around the care that the entire nursing care team—including PCAs—was delivering to older adults. Further definitions about the scope of practice for these types of workers are provided in Appendix A. In the following section, I describe inclusion criteria and methods of sampling.

4.4.1 Inclusion Criteria

My initial inclusion criteria included only nurses who were able to speak English, held at least a half-time position, and had worked a minimum of one year. English-speaking participants were specified because the study was conducted in an English-speaking hospital where it would be necessary for employees engaging with the public to be able to speak English and I, as the person conducting the interviews, only speak English. Nurses who worked a minimum of half-time for a year were specified because it was anticipated that participants needed to have adequate exposure to older adults in acute care settings to be able to reflect on the meaning-making that occurs in concert with other care providers. As the study unfolded, I noted that there
were differences in how nurses with many years of experience and newly graduated nurses approached their nursing practice with older adults. My observations of the meaning-making that was occurring with novice nurses and with experienced nurses contributed to the subsequent inclusion of nurses who had recently graduated and nurses who had decades of experience as participants in this study. Sampling for incidents from these diverse participants contributed to the theoretical development of how nurses work together, and how they learn from one another about older adult care. For example, novice nurses asked more experienced nurses about the most appropriate approaches to managing older adults who were exhibiting challenging behaviours due to cognitive deficits. This practice became a property of a category in the developing theory.

4.4.2 Sampling

In order to ensure theoretical saturation (when further data yields no new incidents to support the categories that have been developed), I used both purposeful and theoretical sampling (Creswell, 1998; Glaser, 1978; Polit & Hungler, 1991; Sandelowski, 1995). When I used purposeful sampling I made a conscious decision to include certain elements in the study (Burns & Grove, 1997). In this study, I began sampling by purposefully recruiting RNs, given their leadership role in nursing care teams. I continued by using snowball sampling, which is used when the research population consists of individuals with specific traits and who are easily available to be subjects (Polit & Hungler, 1991). In this case, my snowball sample included nurses who worked on particular units.

I also sampled theoretically, as I developed categories to include novice and experienced nurses who contributed to the properties of categories. Glaser (1978; 2001) explained that the researcher collects, codes, and analyses data concurrently and thus decides what data is needed to
aid in the theory development. In this way, theoretical sampling ensures the incidents account for
the most variation in the data. I also used theoretical sampling to include other types of incidents
with participants, such as their interactions with care managers, educators, physicians, and
physical therapists to enrich the development of the categories of the theory. After obtaining
consent from these individuals, their perceptions and interactions with nurses were included in
the observational data.

4.5 Ethical Considerations

Prior to conducting this study, I obtained ethical approval from the University of British
Columbia and from the relevant health authorities. I obtained agreement to conduct the study on
particular units from the managers of the units prior to recruitment of participants and participant
observation. This was an important step because data collection included participant observation,
interviews, and review of documents (such as the posters on the unit). In the following
paragraphs, I discuss ethical considerations related to the nature of participant observation, the
potential vulnerability of older adult patients, and confidentiality.

4.5.1 The Nature of Participant Observation

Participant observation is an unstructured method of collecting research data through the
observation of interactions that occur in the area of interest (Polit & Hungler, 1991). It provides a
rich understanding of human behaviours within social situations that is only possible by being
present in the field (Burns & Grove, 1997). The central tenets for both SI and GT support the
examination of what is going on in the area of interest by witnessing how people are behaving in
social situations (Glaser, 1978; Mead, 1934).

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6 The ethics numbers associated with these approvals are listed in the preface.
Participant observation was an important element of this study because it provided opportunities for me to see nurses creating lines of action with others in a variety of nursing care situations. I was acutely aware that I was not an unseen observer; I was another person on the nursing units. To explain my presence there were posters providing information about the study with my contact information on the participating units (Appendix B). I also began each observation shift by explaining my presence as a nurse researcher on the unit. I provided information cards to nurses, other healthcare professionals, patients, and families as a means of introducing them to both the purpose of my study and my links with an academic institution (Appendix C). I explained to all of these individuals that I would not include written documentation of what they were doing and saying, unless they chose to be a participant and signed a consent form. Individuals who expressed an interest in learning more about being a participant in the study were provided with a consent form (Appendix D). Individuals who expressed an interest in allowing their interactions with the nurse participant to be included as data were also provided with a Bystander Consent Form (Appendix E).

4.5.2 Older Adult Patients

Even though older adults were not the intended subjects of the study, by observing nursing practice with hospitalized older adults, I was observing nurses’ interactions with older adults. Prior to shadowing a nurse as part of participant observation, whenever possible, I would go to the unit the day before and ask the participating nurse to give information cards to the patients for whom he/she would be responsible the next day (Appendix C). At that time, I was available to answer any questions. There were many older adult patients who were able to understand and provide informed consent for participant observation (Appendix F). For those who were unable to understand due to language barriers, I had information cards, consent forms,
and assent forms in both Chinese (Appendix G) and Punjabi (Appendix H). Whenever there was any concern that a patient may not be able to understand what their consent indicated, I discussed the study and obtained consent from the patients’ designated decision-maker (usually available next of kin). I also explained my presence to the older adults and obtained their assent (Appendix I). I left a copy of the Patient Assent Form at these older adult patients’ bedside. Finally, I gave older adults’ families a Family Consent Form to review so they could have the opportunity to have their interactions with the nurses become part of the data (Appendix J).

Despite my best attempts to obtain informed consent from all older adult patients prior to my observation shifts with nurses, it was not always possible to anticipate which patients the nurse would be assigned the next day. In these types of situations, the nurses explained to their patients that a nurse researcher was shadowing them, and asked if they agreed to the researcher coming in to meet them. If they agreed, I gave them an information card and briefly explained why I was there. All but one patient (who was able to consent) smiled and assented to my presence. I gave them a consent form to review and returned later to see if they had any questions or concerns.

In situations where I did not have written consent from older adults patients (or their designated decision-maker, if the older adult was not able to consent), I limited my documentation to what the nurses were doing and saying, without incorporating the patients’ responses in my notes. After we left the patients’ rooms, I would ask the nurses about their perceptions regarding the patients’ responses to their interventions, and I included the nurses’ perceptions of the patients’ responses in my observational data.
4.5.3 Confidentiality

All participants were informed about my efforts to maintain their confidentiality. For example, I changed all names of participants in the transcription process. Furthermore, I stored all of the data collected in a locked cabinet and on a computer that was password protected. My transcriptionist signed a confidentiality form. During the consent process, I informed all participants about the limits of confidentiality. I explained that I was a nurse researcher and was responsible to the professional obligations of a nurse. For example, if I witnessed abuse, I would be obligated to report what I observed (Canadian Nurses Association, 2008).

4.6 Research Procedures

The data collection methods for this study included interviews, participant observation, and review of documents (Glaser & Strauss, 1967). As I indicated previously, these methods (in particular, observing participants’ behaviour in their social world and listening to what participants believe is important to the problem they are trying to solve) are important elements of both GT and SI (Glaser, 1978; Mead, 1934). In what follows, I describe the research procedures, beginning with recruiting participants, through to data collection and data analysis. Although these procedures will be discussed separately, it is important to note that data collection and data analysis occur concurrently in a GT study (Glaser & Strauss, 1967; Glaser, 2001; Simmons, 2011). Moreover, my recruitment of participants was ongoing due to the requirement of theoretical sampling to sample further incidents.

4.6.1 Recruiting Participants and Obtaining Consent

After ethical approval had been obtained from the university and the participating health authorities, I began recruitment through my connections with the Clinical Nurse Specialist (CNS) associated with each of the units. The CNSs provided introductions to the managers, who
gave me permission to hang posters (Appendix B) and leave information cards on the units (Appendix C). Nurses who were interested in participating either contacted me directly or through the manager or nurse educator. An invitation to attend a staff meeting on one of the units provided an opportunity for me to explain the study. In the following section, I describe how I conducted recruitment and obtained consent.

4.6.1.1 Recruitment

At the beginning of the data collection process on each unit, I was assigned to a nurse to familiarize myself with the unit. During my time with that nurse, I had an opportunity to introduce myself to other nurses and healthcare practitioners on the unit, explain why I was there, and indicate that I was looking for participants. A few nurses volunteered to participate in my study on both units during the first day. My recruitment snowballed after the initial participants agreed. Each day I was on the units, nurses came forward to volunteer, and participants talked to their colleagues suggesting that they should also volunteer. When I realized that the participation of more experienced nurses could add incidents that would enrich the theoretical development of my study, I explained my interest in shadowing experienced nurses in order to learn how they were creating lines of action in their practice. After my interest had been identified, a nurse with over 30 years’ experience volunteered for the study.

4.6.1.2 Obtaining consent

When participants volunteered to participate in this study I provided them with the consent form to read over, answered any questions, and provided them with a copy of the consent form for their records (Appendix D). In the case of participants working with other nurses, I only included data about their interactions with these individuals if the other nurse signed a Bystander Consent Form (Appendix E). This consent form indicated that nurses and
other healthcare providers who worked with the nurse I was observing (bystanders) were participating in my study by allowing their interactions with the participating nurse to be included as data. All but two bystanders signed this consent form. I excluded data about the nurses who did not sign one of these consent forms. In such situations, I documented my experiences of observing interactions and being unable to record them as part of the study in my field notes\(^7\) (details provided on page 58) and memos (details provided on page 59).\(^8\)

The Bystander Consent Form (Appendix E) included an option for the participant to agree to an interview with me at a later date. Of the 19 nursing bystanders, five agreed to be interviewed and three of these nurses signed a Participant Consent Form (Appendix D) so that I could also conduct participant observations with them. Having access to both participant observation and interviewing with the same participants was important because I could not only observe their behaviours and lines of action but I could also ask them about the meaning those actions held for them.

### 4.6.2 Data Collection

Although data collection and data analysis occurred concurrently, I discuss data collection first. Data were gathered primarily through participant observation (see guide in Appendix K) and semi-structured interviews (see guide in Appendix L). Documents related to nursing practice (e.g. the Kardex\(^9\), posters, and care planning aids) were examined as the nurses

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\(^7\) Field notes were the written documentation of what I was observing during participant observations. I included any questions I had about what I was seeing or hearing during observations to ensure those questions were not forgotten when the opportunity to discuss the situation with the participant occurred.

\(^8\) Memos are the theoretical musings about what the research thinks might be occurring in the data (Glaser & Strauss, 1967).

\(^9\) Kardex is a written document that contains the patients’ diagnosis, treatments the nurse must do, the frequency of vital signs, the doctor’s orders for intravenous, collection of specimens, and scheduled tests. It is intended to present the important facts quickly for the nurse to understand what the priorities are in patients’ care.
used them during my participant observation. In what follows, I describe the specifics of data collection strategies used in participant observation and the context of my interviews.

Data collection occurred over 12 months; I began with participant observation shifts on a geriatric unit at the first hospital site. Interviews with nurses I was observing were scheduled at their convenience. Six months later, after data collection and data analysis were well underway at the first site, I was finding similarities in many of the incidents I was sampling and the properties I developed to represent the incidents were being saturated. As a result, I began participant observation shifts at the second hospital site on a medical unit. Five months later, the incidents I was sampling on that unit also no longer added new information to the developing categories and I had some preliminary ideas about the theory. I conducted second interviews with selected participants to discuss my ideas. Participants were asked for their perceptions of whether the developing theory and preliminary categories explained the problems they were trying to process in their practice.

4.6.2.1 Participant observation

As explained earlier in this chapter, participant observation was an important method of data collection because it provided an opportunity for me to witness nursing practice in action. Prior to engaging in participant observation, I discussed with the managers ways that would be acceptable for me to act as a participant, such as making beds with the nurses, or retrieving supplies for them. I recognized that my presence and my questions added to the nurses’ workload and I viewed the ways I was able to assist as a form of reciprocity. I also found that helping in these ways deepened my reflection about the challenges nurses were facing in their work.

I conducted 375 hours of participant observation; 275 hours were on the geriatric unit and 100 hours were on the medical unit. The blocks of time I devoted to participant observation
varied from four-hour periods to 12-hour shifts. My observations occurred over a variety of times in the 24-hour clock. I included observational times on weekends and on statutory holidays. During participant observation, I would excuse myself to find a quiet space to write my observations via my computer, which was password protected and stored in a secure location. I interrupted my observations to write every hour or two depending on what was occurring on a particular shift. It is important to note that my participant observation was active in the sense that I engaged the nurses in conversation about what I was observing.

Between these writing sessions on my computer, I hand-wrote notes on a pad I kept in my pocket at all times. The general focus of my observations was the interactions among nurses, between nurses and other healthcare professionals, and between nurses and older adult patients (see Appendix K for the observation guide). In other words, I noted nurses’ behaviours and the development of their lines of action with those I have named. I also described the physical details of the environment and the activity levels of the unit. For example, I would include comments about the presence of many doctors making rounds, or the phone ringing constantly. During these observation days, I also wrote emerging questions in my field notes.

Following my observation sessions, I wrote memos about the social interactions I observed and how any conversations assisted me to access the nursing team. For example, in the field note written November 29 (Appendix M), I reflected on a conversation the nurse and I had been conducting for most of the day about the positive strokes nurses receive when they are efficient, and how this reinforcement by management discourages requests for assistance. Another example is evident in a memo I wrote very early in data collection on June 10 (Appendix N), where I reflected that much of nursing practice in the research settings occurred behind the scenes away from the patient and I wondered if this was the same in all settings.
These types of reflections and questions were also explored in the audio-recorded interviews with these participants. The nurses also provided insights into my ongoing analysis of the data.

4.6.2.2 Interviews

The interviews provided me with an opportunity to hear participants’ perspectives about what was most important in their nursing practice and to determine how they made meaning of what I had observed. Interviews have been identified as an important data collection method for both GT and SI (Glaser & Strauss, 1967; Mead, 1934). Open-ended questions (found in the preliminary interview guide in Appendix L) were used to start the conversation. Active listening and paraphrasing what I understood the participant to be saying also facilitated communication in the interviews.

The semi-structured interview format allowed me to be reflexive and to co-construct meaning in each interview during participants’ descriptions of their experiences. My questions were used to elicit how nurses enacted nursing practice with hospitalized older adults and what nurses believed facilitated and constrained their practice with hospitalized older adults. For example, during one of the participant observation shifts I responded by defending a novice nurse when an intensive care unit (ICU) nurse was treating her (in my opinion) harshly. I had reflected on my intervention and wanted to understand the nurse’s perceptions of the event. When I discussed this incident with the nurse, I learned that my actions contributed to her meaning-making about what was helpful and unhelpful assistance from more experienced nurses. Being guided by SI helped me to identify how I contributed to meaning-making with this nurse, and that my actions, my reflections of my actions, and my subsequent discussion of those actions with the nurse assisted both of us in clarifying the meaning of the situation. This situation and our conversation about the situation contributed to my development of the theory.
I conducted a total of 35 interviews, of which 12 were second interviews. One of the 24 participants was off on medical leave shortly after her participant observation shift, thus an audio-recorded interview with her did not take place. The interviews ranged in length from 20 to 90 minutes, depending on participants’ available time. The total amount of interview time was approximately 27 hours. Study participants provided basic demographic information such as age, education, and years of experience at the beginning of each audio-recorded interview (see Appendix L). Interviews occurred at a location of the participants’ choosing. Two interviews occurred in participants’ homes, one was in my home (at the participant’s request), three were in a quiet corner in a coffee shop, and the remainder of the interviews occurred in a private conference room at the hospital. I wrote field notes immediately following interviews to record participants’ physical appearance, behaviours, and nonverbal communication such as affect, mannerisms, and facial expressions. All interviews were audio-recorded and transcribed as soon as possible.

Although initially I anticipated that one interview with each participant would be sufficient, in keeping with the tenets of GT, I remained open to further interviews as I was developing the theory. I conducted second interviews with participants who were available after a period of several months. These interviews enhanced my development of the theory because several participants supported my analysis but indicated I was not giving enough importance to one of the categories. They explained that the category I labelled *orchestrating was a very important element in their work and that it could be considered the essence of what they did. These conversations sensitized me to the importance of *orchestrating care as I was developing the theory.
4.6.2.3 Documents

Concurrently with my participant observation sessions, I examined documents that the nurses considered meaningful in guiding their practice concurrently with my participant observation sessions. Theorists using SI have indicated that documents can be an important source of data to help determine how individuals make meaning of their actions (Blumer, 1969; Mead, 1934). Thus, I was interested in the information nurses used in the Kardex. On both units, there were documents that were either in the form of a poster or in hanging folders that were used in the care planning process. My review of these documents was based on my interpretation of nurses’ perceptions of the information they required and found useful in their practice with hospitalized older adults.

Nurses’ use of documents became part of the field notes I wrote during and after participant observation, as well as conversation points during interviews. For example, as noted in the field note dated August 11 (Appendix M), one of the nurses had explained that the care plan in the Kardex was not kept up to date, and indeed, as the day unfolded, it happened that plans for a patient’s discharge went awry because the information had not been in the Kardex. The nurse explained that had she known the plan she would have acted differently. The nurse stressed the vital nature of their communication tool (Kardex) as she spoke with me and all the nurses who were working on the unit that day. Through these conversations and the circumstances of the day, I came to a greater understanding of the importance of these communication tools for nurses and how their care was affected when the information was not current. In these ways the meaning that nurses were making from their documents aided in theory development.
4.6.2.4 Field notes

I used the field notes as data in keeping with GT precepts that everything is data (Glaser, 1992). Because I took notes during participant observations I was able to include quotes from nurses or other health professionals that arose during my conversations with them. Reviewing the field notes helped me to generate questions to ask during interviews with participants and allowed me to develop conceptual thinking about what was happening and incorporate my thinking into a memo. In the previous example when I had intervened and defended the novice nurse from the ICU nurse’s harsh words, my field notes helped me to reflect on my actions and what was behind my belief that I needed to protect the nurse. The discussion I had with the novice nurse as a result of this incident further sparked my thinking about experienced nurses watching over novice nurses. This line of thinking developed into conceptual ideas about the relationships between helping and roles, as well as how nurses navigate their relationships with others.

I also engaged in reflexive writing in my field notes about the balance between potential benefits and potential harm to older adults as a result of data collection and their capacity to provide informed consent. For example, there was one older adult patient who consented one day and was very eager to talk to me about his experiences in the hospital. On the next shift, he became delirious due to his medical condition and his delirium included paranoid thinking about my research. I reassured the man that I would remove his interactions from the data and avoided any further contact with him to honour his wishes and decrease his discomfort about the research.
4.6.3 Data Analysis

I analysed data concurrently with data collection using the constant comparison method that is characteristic of GT. My analysis included techniques of intense memo writing, three stages of grounded theory coding (open, selective, and theoretical coding), and theoretical sensitivity (Glaser & Strauss, 1967; Glaser, 1978, 1992; 2001). Symbolic interactionism also guided data analysis in terms of paying attention to nurses’ interpretations of their interactions with one another and with objects, such as the Kardex (Blumer, 1969; Mead, 1934).

4.6.3.1 Memo writing

Theoretical memo writing is critical to developing a dense and parsimonious grounded theory (Glaser, 1978). It is in writing memos that the creative process of theorizing and conceptualization of the data occurs. Glaser suggested that recording ideas and insights as they happen aids in the process of theory generation. I can concur with his view; at one point, I was not writing memos but rather was discussing my ideas with other doctoral students. I believe this contributed to the sense of feeling stuck that I experienced because I was articulating my thoughts and letting them go without writing them down. When I began writing more memos about my thinking before talking to others I was better able to capture my conceptual thinking that could be forgotten after a conversation.

Memos helped me to conceptualize the information in my notes about participant observation and my interviews. An example of this is evident in the memo on oughts (see November 1, 2010 in Appendix N). In this memo, I started to explore what nurses saw as the important aspects of their care with older adults. In a later memo dated April 22, 2011 my conceptual thinking about what I originally explained as oughts was beginning to develop into nurses’ goals in providing what they defined as good care. Glaser (1978) identified that memos
allow the sorting and reworking of ideas that are essential to writing the theory. When my ideas were not clear, writing memos helped me to identify when more information was required, and when theoretical saturation had occurred. After recognizing that I was writing about the same incidents at both sites and no new incidents that contributed to the developing categories were being sampled, I decided that theoretical saturation had occurred. Memo writing also helped me refine my language to capture processes more clearly than the existing labels of categories and properties. For example, in a memo on April 11, 2011 (Appendix N) I wrote about my thinking about orchestrating care. In a later memo written on November 12, 2011 (Appendix N), it is evident how my thinking about how to articulate the categories of orchestrating care had developed. I was beginning to conceptualize how orchestrating care could explain how nurses were constantly assessing their patients and circumstances (doing reconnaissance), and trying to stretch their resources to meet what they saw as their patients’ most pressing needs (maximizing resources—described as coordinating in this memo).

4.6.3.2 The stages of grounded theory related to coding

I used the four stages of analysis related to GT: comparing incidents, integrating categories and their properties, delimiting the theory, and writing the theory (Glaser & Strauss, 1967). To guide my coding and analysis, I asked the questions Glaser (1978) suggested: “What is this a study of? What category does this incident suggest? And what is happening in the data?” (p. 56). I explain how I engaged in the four stages of analysis through the coding process in the following sections.

4.6.3.3 Coding

In order to conceptualize the data, I began by labelling incidents as well as comparing incidents with one another. After labelling and comparing incidents, I clustered similar incidents
to form categories. I compared incidents and clustered incidents, which led to the development of more categories and their properties. For example, early in the analysis I identified that many of the incidents such as safety, misconceptions about older adult care, heavy nature of the work, and time strategies were occurring frequently. I wrote them on recipe cards and laid them out on the floor, grouping incidents that seemed similar so that they formed categories. Symbolic interactionism guided me in this process through my reflections about how nurses were symbolizing objects—such as restraints, heavy older adults, and the Kardex—in the incidents I had sampled and how the nurses were interacting with one another on their units (Blumer, 1969; Mead, 1934). Through this coding process, I collapsed incidents into categories and their properties.

I conducted three levels of coding: open, selective, and theoretical coding. Open coding is the initial line-by-line coding that I used to develop the substantive codes. Selective coding was used to delimit coding to include only the variables that related to the core variable (Glaser, 1992). Theoretical coding aided in developing the conceptual relationships among the categories and the core variable and was used to conceptualize participants’ main concerns and how they were resolved. Developing theoretical codes enabled me to integrate the theory (Glaser, 1978; 1998; 2001).

4.6.3.3.1 Open coding.

I began the coding process with line-by-line open coding. Glaser (1978, 1992; 2001) advised researchers to remain open to what might be in the data during this process. I wrote notations in the margins of the transcripts while doing this line-by-line coding. These in vivo codes were constructed from the incidents in the data. Some examples of in vivo codes are we communicate, helping each other, and we work together. The process of raising the conceptual
level of analysis occurred through grouping similar incidents to form categories and grouping
dissimilar incidents, which I identified as properties of categories. The code helping each other
was an incident that was described frequently by nurses, leading me to identify that the concept
of helping was important in this theory.

Early on in this analysis process it became clear to me that keeping patients safe and
progressing patients (increasing their functional abilities) were important concerns to the nurses.
Other important concerns to nurses were how to obtain resources, and ensuring clear
communication about their patients. I believed that keeping patients safe and progressing patients
were important categories in nursing practice with hospitalized older adults because of the
frequency of the incidents and the extensive properties supporting these categories in the data. It
was useful when I went back to participants and explained my preliminary ideas about the
category development. They suggested that although I was getting close to nurses’ perceptions of
what was important, the category of orchestrating (which I had developed as a property of
progressing) better explained their practice. The participants clearly identified that orchestrating
care was key to what they were doing to resolve their main concern, and as I continued with my
open coding, it seemed to me that keeping patients safe and progressing patients were goals that
the nurses were trying to achieve as part of orchestrating care.

Grounded theory analysis is not a linear process; it is one where the researcher can return
to the data collected earlier with new questions that have been developed from subsequent data
collection and analysis (Glaser, 1978). At this point after conducting second interviews, in
keeping with Glaser’s (1978) suggestion of asking questions of the data, I asked three questions
to shift my thinking. I asked of the data: What are the nurses facing? What are they doing? And
what are their thoughts and feelings? Returning to the data once again with these questions in
mind assisted me to conceptualize the data in different ways. Many of the vivo codes I had initially identified as categories were developed into the properties of the more abstract categories I was developing. For example, helping each other was developed into one of the properties of the category building synergy. As another example, adapting approaches contributed to the properties of the category minimizing strain. This process was similar to Glaser’s (1978) explanation of how categories that are thin will be collapsed into other categories.

As I developed the theory, the process of delimiting assisted me to reduce the data because I was able to recognize underlying similarities in categories. For example, I developed coordinating resources, building synergy and defining the common good early in my analysis as three important categories in nursing practice with hospitalized older adults. Discussion about these categories with my dissertation committee sparked further analysis. It became clear that the concept of coordinating resources did not adequately represent a key category; however, it did provide information about the properties of the category minimizing strain. As Glaser (1978) suggested, after I ceased open coding all of the categories and their properties were developed as fully as possible, and the processes were constructed. Following open coding, selective coding began.

4.6.3.3.2 Selective coding.

I began selective coding by delimiting the coding to a core category and its properties (Glaser, 1992). My second interviews with participants and their perceptions of my conceptual thinking about their key process assisted me in delimiting for a core category. The following quote is similar to other responses I received from participants about the importance of orchestrating to their practice: “I think orchestrating is the part we’re doing a lot of” (RN 12,
Interview 2, Site 2). I returned to the data questioning if orchestrating care could be the core variable. I consulted with members from my dissertation committee about my theory development. This led me to realize that my previous conceptualization of the data was forcing the data into a category that served to offer only a description of nurses’ practice.

Glaser identified that there are many types of coding families and not all of them have distinct stages (Glaser, 1978). My understanding of his thinking freed me in conceptualizing the subprocesses within the core variable of orchestrating care. Many incidents that had been represented in other tentative conceptualizations of categories were moved to be the subprocesses and properties of this core variable. By changing my thinking, I was able to collapse thin categories and provide a core variable with interchangeable incidents that accounted for the most variation in the data. The two categories of building synergy and minimizing strain were developed to explain how nurses were orchestrating care. Building synergy was explained through the properties of doing reconnaissance, passing information, and navigating relationships. Minimizing strain was explained through the properties of maximizing resources, learning the work, and reframing the work. The selective coding process served to focus my attention on data that represented the core variable and helped me to explain the core variable. This served to enhance theoretical saturation; it also assisted me in clarifying the logic of the developing theory (Glaser & Strauss, 1967).

4.6.3.3 Theoretical coding.

After selectively coding for a core category, I began to use theoretical coding to explain how the categories were related to one another. Theoretical coding is used to hypothesize about the relationships among categories, to clarify categories, and to develop a theory through an enhanced understanding of the theoretical relationships (Glaser, 1978; Glaser & Strauss, 1967).
Operating at a conceptual level, I used theoretical codes to develop conceptual relationships between categories and their properties. For example, the codes assessing patients, assessing staffing, and assessing the unit were conceptualized as properties of doing reconnaissance. I conceptualized doing reconnaissance, passing information, and navigating relationships as categories of the subprocess building synergy. Furthermore, building synergy and minimizing strain were conceptualized as subprocesses comprising the core category of orchestrating care. These theoretical codes became conceptual connectors that supported hypotheses about how participants were managing their main concern. I used a variety of metaphors and conceptual diagrams to aid in developing linkages among categories. These diagrams were reworked as the data analysis continued. Although the originators of grounded theory claimed that data integration would emerge naturally if theoretical sampling and concurrent analysis were used (Glaser & Strauss, 1967), this was not my experience. Rather, as would be suggested by SI—my guiding theoretical framework—I constructed the theory through my interaction with the categories and my participants.

I used theoretical coding, integrated categories, thereby developing the researcher’s understanding of theoretical relationships as suggested by Glaser and Strauss (1967). An example of this is the process of minimizing strain. As mentioned earlier, I identified keeping patients safe as an important goal for participants. As I explored the data theoretically to examine nurses’ motivations for particular interventions, such as physical restraints, and their nonverbal communications about these interventions, I identified the link between nurses using restraints and keeping their older adult patients safe. At the same time, the nurses identified that restraining people was not within best practice guidelines. I used the theoretical coding process to develop the theoretical code reframing that captured how nurses symbolized restraints as safety
restraints, which was a means of reinterpreting these undesirable practices. This example explains how I developed the relationships among the categories.

I was writing the theory when the theoretical connections between the categories building synergy and minimizing strain were developed. Symbolizing nurses’ experiences working in settings where they felt misunderstood, ignored, and underresourced as “feeling besieged” helped me to conceptualize the insular nature of nurses’ practice and how they were identifying the healthcare system as the root cause of their problems. This conceptualization represented minimizing strain as a means for nurses to develop a supportive network to process their negative feelings about the negative aspects of their practice. It also helped me in articulating how this supportive network of nurse allies was interfering with the other subprocess of building synergy because nurses were limiting their possible allies as they were building synergy.

Key to my conceptualization of this theory was my ongoing discussion with my supervisory committee and referring back to the theoretical framework of SI to guide my thinking. Within these discussions, the process of posing questions about the developing theory and categories served to enhance my conceptualization of the theory. Glaser (1978) highlighted the importance of this type of intellectual challenge in moving the theory forward. In these discussions, along with the final stage of the constant comparative analysis of writing the theory, the feedback from my committee was an important element in refining the relationships among the categories and their properties. Glaser (1992) suggested that writing the theory was an important phase of analysis because categories and their relationships become further refined as they are written. I discovered that writing the theory pushed my thinking about nuances of the relationships among the categories. For example, while both subprocesses were necessary parts of orchestrating care, minimizing strain could interfere with building synergy.
4.6.3.4 Theoretical sensitivity

Theoretical sensitivity refers to the “researchers’ knowledge, understanding and skill, which fosters his generation of categories and properties and increases his ability to relate them into hypotheses, and to integrate the hypotheses according to emergent theoretical codes” (Glaser, 1992, p. 27). My experiences as a nursing instructor, as a manager, and my exposure to the literature in those arenas, sensitized me to observe interactions from a unit perspective as well as interactions among nurses and other healthcare professionals. I wrote memos about these perceptions and then asked nurses about their perceptions to frame my experiences with what was occurring in these nurses’ practice. Although I made a conscious effort to enter the research process with as few preconceived ideas as possible as recommended by Glaser (1978), my familiarity with the literature and my experience in these areas of nursing practice and older adults increased my theoretical sensitivity. For example, I was well acquainted with the importance of function as a signal of potential illness in older adults, I carefully considered the potential effects of my familiarity with the literature and experience on how I conceptualized my theory and attended to inadvertently adding theoretical perspectives into my theory development. My theoretical sensitivity also influenced my understanding of theoretical codes. For example, my years of experiences in nursing and my exposure to the literature caused me to be open to the concept of nursing as a team sport or nurses needing others to enhance the care of their patients. My awareness created openness to the theoretical development of the code building synergy. Moreover, my reading about the grounded theory method also contributed to my theoretical sensitivity in the process of data collection and analysis.

I wrote memos about my perceptions of what I observed in the field and what I observed in my own practice, and carefully reflected on whether there were similarities or differences. This contributed to my theorizing. I asked questions about what might be going on based on my
reflections about the data and used these reflections to further inquire of participants about their experiences. For example, as a seasoned nurse I am accustomed to conducting a general assessment of the unit on which I am working and the nurses with whom I am working. In participant observation, I noticed that this type of general assessment differed among the nurses. My observations sparked conversations with nurses about what they were assessing and the reasons why they were conducting a particular type of assessment. These conversations facilitated the development of the category of building synergy and the properties of doing reconnaissance, passing information, and navigating relationships. When I examined how nurses viewed roles within the nursing team and with other healthcare professionals, I reflected on my negative and positive experiences working with other nurses and healthcare professionals. I was careful to write about participants’ perceptions and to check with them to determine if I had accurately reflected their perceptions in the conceptual development of the theory.

4.6.4   Rigour

There are general considerations for rigour in qualitative research and more specific criteria in GT methods. Rigour in qualitative research is evidenced by openness and adherence to a philosophical perspective during the development of a theory (Burns & Grove, 1997; Sandelowski, 1986). In the preceding chapters, I have identified the decisions that I made to conduct this study using the theoretical framework of SI and GT methods. In this chapter, I have described recruitment, data collection and data analysis. Examples have been used to demonstrate how data were coded, how categories were developed, and how theoretical decisions about inclusion of participants and categories were made. These examples and the many others that were described in my theoretical memos provide a transparent decision trail.
about the decisions that were made in the development of this theory. These decisions contribute to the credibility of the data analysis by increasing its auditability (Burns & Grove, 1997).

I have assessed my study using the specific criteria for rigour in GT as developed in Glaser’s (1978) book, *Theoretical Sensitivity*. These include the elements of fit, relevance, work, modifiability, parsimony, and scope. I have added the elements of reflexivity and relationality in recognition of how SI, as my theoretical framework, guided the study, specifically through addressing the co-construction of meaning that occurs between the researcher and participants and balancing the subjective influences of the researcher (Hall & Callery, 2001).

**4.6.4.1 Fit**

Glaser (1992) indicated that if the categories and their properties fit the problems from the perspective of the participants, then the theory fits. The main concern that nurses were processing through the theory of orchestrating care was providing what they perceived to be “good care” while surviving as a “good” nurse. I assessed the fit of my theory by examining incidents and the categories I used to conceptualize the data; they fit how nurses were processing their problem. This process aided me in determining whether the category labels were the best representation of the patterns that I was seeing in the data.

**4.6.4.2 Work**

Since the theory will work only if it is able to explain what has happened or is happening in the substantive area, ultimately the reader will be the judge of whether or not the theory works. Glaser (1992) explained that the core category must explain the major variations in behaviour with respect to the processing of the main concerns of the participants (p. 15). I argue that the constant comparative method allowed me to develop categories that accounted for maximum variation in the nurses’ behaviours. By discussing preliminary ideas about the theory
with participants in the second round of interviews, I was able to validate their interpretations of caring for older adults as well as how they were managing these concerns.

4.6.4.3 Relevance

Glaser (1992) described relevance as the relationship that the theory has to the problems identified by participants and a criterion achieved if the theory fits and works. During the second round of interviews, participants identified the relevance of this theory. They agreed that I had identified their core issues and was on the right path to explaining how they were dealing with these issues. As has been mentioned earlier, nurses’ insistence that I pay attention to orchestrating care because it was key to how they managing their work, helped to me to adjust the importance of the category as the core variable rather than as a sub-category. Moreover, by adhering to the GT principles of constant comparison and writing memos about conceptual decisions in theory development, I found that the concepts earned their way into the theory from the data (Glaser, 1978).

4.6.4.4 Modifiability

Modifiability is considered achieved when the theory is able to incorporate new data with variations in properties and categories (Glaser, 1978). In this way a theory has the potential to integrate new categories to explain other similar phenomena (Glaser, 1992). Since circumstances in the acute care hospitals can change, it is important that the theory reflects the dynamic nature of the process about how nursing practice with older adults is enacted. Moreover, modifiability is also about how this theory might be applied in other settings. As Glaser (1978) explained, the theory will need to reflect the problems and issues in a manner that acknowledges that nothing is static; the problems and the way that players interact are dynamic and changing. The theory of orchestrating care attends to the changing context of older adult patients and the acute care
context by reflecting nurses’ engagement in prioritizing, and symbolizing their work to adapt to the shifting context. For example, nurses were symbolizing their patients as either acute or heavy to aid them in prioritizing their lines of action while doing reconnaissance. Moreover, they were symbolizing their undesirable practices in positive ways through sedating and safety restraints as they were reframing their work.

4.6.4.5 Parsimony

Parsimony means that the theory accounts for the most variation possible in the data with the least number of concepts (Glaser, 1978). By undertaking the systematic process of coding and delimiting, according to Glaser’s (1978) analytic rules, the theory should be delimited for one core variable and other categories and properties are to be delimited for how they relate to the core variable to no more that 10–15 categories. In this theory, I had one core variable of orchestrating care and two subprocesses of building synergy and minimizing strain for a total of nine categories. These subprocesses and their properties help to explain the core variable. Because I developed the theory to account for maximal variation in the data with a minimal number of concepts it can be considered parsimonious.

4.6.4.6 Scope

Scope means that the theory could have application in explaining other similar problems that humans are processing (Glaser, 1978). The theory of orchestrating care could be helpful in understanding nursing practice with older adults in rehabilitation settings, and may also be applicable to other settings where nurses are practicing with older adults, such as residential care settings. In this way there is scope to this theory.

4.6.4.7 Reflexivity and relationality

I added reflexivity and relationality to the GT elements of rigour, because the sensitizing framework of SI acknowledges the social construction of data and theory (Hall & Callery, 2001).
I attended to reflexivity by examining the influence of my underlying beliefs, values, experiences, and assumptions on my interpretations of what I saw, heard, and thought about nursing practice with hospitalized older adults throughout every stage of the research process. Early in the data collection I recognized that my experiences as a nurse for many years in a variety of roles sensitized me to observe interactions from a unit perspective and interactions among nurses and healthcare professionals. I wrote memos about my observations and asked myself questions about my perceptions. This personal reflection aided me in formulating clarifying questions to ask participants about their perceptions. Moreover, as nurses began to trust me, they described feeling not valued within the healthcare team because they were not invited to care planning meetings for their patients and because their requests for help were often ignored. I reflected on my personal experiences in meetings with other healthcare professionals when nurses’ participation was seen only as commenting on aspects such as bowel patterns. I wrote reflections about these experiences and how my perceptions could be similar or different from the participants in this study. These reflections aided me in developing the theory that was reflective of participants’ view of their concerns.

I was aware throughout the research process that my personal family background of being exposed to a very active, healthy grandfather who lived to 99 has had considerable influence on how I view aging. I was aware that my perceptions about aging may or may not be shared by other participants. I found the concepts in SI, the personal self and social self (Blumer, 1969) useful for thinking about how my perspective influenced my relationships with the participants. I shared with participants my perceptions that my views about older adults were shaped by my grandfather. Sharing this personal reflection frequently caused participants to share their views about what shaped their own perspectives. In this way, I was able to learn more
about participants and how they made meaning of their work with older adults. I was also able to recognize that I was engaged in constructing meaning with participants throughout the research process, rather than being an objective observer (Hall & Callery, 2001). The process of conducting this research provided me with the opportunity to be reflexive about my nursing practice and how I and other nurses with whom I had worked had symbolized our practice. This to me is the greatest gift of this research process.

Malacrida (2007) suggested that by being reflexive, there is the potential for the researcher to feel emotional responses about the subject matter and, if explored, these emotional responses can lead to greater insights about the subject. This was certainly the case for me. For example, during one night shift I observed a PCA trying to overhear a conversation between two RNs so he could pass on information to a patient about the care plan they were discussing. In speaking with him later, I learned how he was often excluded from these kinds of conversations At the time, I wanted to defend and articulate the importance of the PCA in providing care and reassurance to patients. I did not; instead I wrote reflections about why I felt the need to defend the PCA. These reflections led me to examine the impact of roles in how nursing teams were building synergy. Ultimately, these reflections led to further questioning with participants, further data analysis, and development of categories and their properties about how nurses are navigating relationships with others who have more or less experience than they do and with team members who have different education levels and roles.

Considering the element of relationality led me to address power and trust relationships between participants and myself (Hall & Callery, 2001) by stressing that I was there to learn from them, and that they were the experts about their own practice. Initially, all that participants knew about me was that I was a nurse researcher. When nurses inquired about my background, I
explained that I had been a nurse for many years in a variety of roles, most of which were in an acute care setting. I did not share that I had been an educator or manager unless questioned further. My aim was to minimize any imbalance in power dynamics by stressing I had worked in a similar role and was very interested in their experiences. I also worked at relationality by encouraging participants to talk freely, with the understanding that the information they were sharing would be kept confidential. I found that nurses increased their trust in me over the time I was on the units; they had begun to view me as a nurse who was also a researcher, rather than as just a researcher. This shift in perceptions served to encourage participants to share their experiences as they would with another nurse who they felt could understand the nuances of their practice. I think that shift in perception was very helpful in minimizing power differences. It was a balance to co-create meaning with nurses about their practice and yet to be questioning as a researcher, asking details that were research focused as well as attending to the relationships I was nurturing with participants.

Some researchers have suggested that attending to the relational aspects of the participant–researcher relationship provides opportunities to reduce power differences and encourages disclosure and authenticity (Karnieli-Miller, Strier, & Pessach, 2009). I agree with those who argue that paying attention to social relationships and symbols provided me, as the researcher, with the opportunity to attend to power within the setting (Dennis & Martin, 2005; Kadlec, 2007). For example, during the process of inviting nurses to participate in the study, I theorized that my decades of experience as a nurse working with older adult populations could contribute to some nurses feeling comfortable with talking to me and could intimidate others. I wrote memos about how my experience could have been influencing nurses’ willingness to participate and sought to explain that I was interested in nurses’ perceptions when I observed that
nurses may have been intimidated by my experiences. In these ways, I paid attention to being reflexive and relational in trying to manage power dynamics.

4.7 Summary

In this study I have given an overview of the GT method used in this study, described the research settings, study sampling procedures, ethical considerations, and research procedures. I have also described how I have attended to the rigour of this study. In the next two chapters, I present my study findings.
CHAPTER FIVE: SETTING THE STAGE

In the next two chapters, I present my study findings, beginning with a description of the participants and the two hospital settings where the research was conducted. Chapter Six follows with my presentation of the grounded theory that I developed to explain nursing practice with hospitalized older adults.

5.1 Participants

Of the 24 study participants, 18 were registered nurses (RNs), three were licensed practical nurses (LPNs) and three were patient care aides (PCAs). The lower level of participation by LPNs is reflective of the ratio of RNs to LPNs that worked on the units. As has been mentioned in the previous chapter, PCAs are not nurses and were sampled to provide incidents about how the nurses were symbolizing the care of older adult patients within the nursing care team that included PCAs.

I conducted participant observations with 20 of these participants, and interviewed 23 of them, with 12 being interviewed twice, for a total of 35 interviews. Most of the participants were general duty nurses (a term used to describe nursing practice that occurs at the bedside with direct contact and responsibility for patient care); the sample also included two clinical leaders, a manager, and one nurse educator (three of these four were bystander participants and were interviewed to provide their perceptions about circumstances that occurred during their interactions with the participant I was observing). Definitions of these roles are provided in the following section on clinical nursing supports (p. 81).

The average age of the participants was 41 years (range 25 to 58 years). Their level of education in the healthcare field varied by job category, ranging from 4 to 6 months (PCA) to 12
months (LPN), with the RNs having completed either a two-year diploma program or a baccalaureate degree program. It was a culturally diverse sample, with 15 of the participants having emigrated from other countries including Europe, Middle East, Japan, India, Philippines, Australia, and South America. All of the nurses either received their nursing education in Canada or had done a refresher program in Canada. Twelve of the participants spoke English as their second language. The following table provides information about the participants in this study.

Table 5.1

<table>
<thead>
<tr>
<th>Participants</th>
<th>Years of experience (Mean)</th>
<th>Years working on the unit (Mean)</th>
<th>Types of positions</th>
<th>Site where they worked</th>
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</thead>
</table>
| Registered nurses: N = 18     | 0.1–35 years (12.3)       | 0.1–11 years (4.83)             | Clinical Leader: N = 2  
Educator: N = 1  
Manager: N = 1  
General Duty: N = 14 | Geriatric Unit: N = 11  
Medical Unit: N = 7 |
| Licensed practical nurses: N = 3 | 1.5–8 (4.2)             | 1.5–2 (1.8)                     | General Duty: N = 3  | Geriatric Unit: N = 2  
Medical Unit: N = 1 |

5.2 The Hospital Settings

The study was conducted on a specialty geriatric unit (GU) in a large tertiary care hospital and a general medical unit (MU) in a community hospital. The hospitals were in different cities and were administered by different regional health authorities. In the next sections, I describe the general characteristics of the older adult patients on these units, the physical environment of the units, and the unit staffing patterns.
5.2.1   Older Adult Patients

The GU followed admissions guidelines indicating that patients were over the age of 70, although nurses reported that they would occasionally have patients who were younger than 65 years. Similarly, during the time of the study on the MU, more than 90% of patients were over the age of 65, despite a lack of age guidelines for admission to this unit. The patients in both settings varied widely in terms of their health status, numbers of chronic diseases, and functional ability, although there was a tendency for patients on the MU to require more support for their activities of daily living,\(^\text{10}\) while those admitted to the GU tended to receive more invasive medical investigations and treatments, such as insertion of chest tubes,\(^\text{11}\) or gastroscopy.\(^\text{12}\) Both units had many older adult patients who did not speak English; Chinese or Punjabi were the most common languages for these non-English-speaking patients.

5.2.2   Physical Environment

The two units were of similar size, each with an expected and funded capacity for 40 patients (although both were overcapacity on a daily basis, with two to four more patients than funded beds). Both units were also laid out similarly, with the 40 beds divided into two 20-bed regions that were a mirror image of each other, and a central supply and desk area in the centre with patient rooms radiating outward. The GU was generally newer looking than the MU, and was physically bigger with larger patient rooms, more single rooms, and a larger desk area with more computers. It also had several empty spaces to accommodate increased bed capacity as necessary. On the MU, extra patients were either on a bed in the hallway or on an extra bed that had been added to a four-bed room.

\(^{10}\) Activities of daily living include bathing, dressing, mouth care, eating, mobility, and bladder and bowel control.
\(^{11}\) Chest tube insertion is a procedure conducted by a physician with the assistance of a nurse. During the procedure the physician inserts a plastic tube into the lung of a patient.
\(^{12}\) Gastroscopy is the insertion of a tube down the mouth to examine the esophagus and stomach.
Both sites gave the appearance of being cluttered, with supply carts and medical equipment lining the hallways, often blocking access to handrails that had been installed to support patient mobility. This was a particular issue on the MU due to its smaller size. The smaller size of the MU also meant that the nurses had to walk fewer steps to retrieve supplies from the desk area and it was easier for nurses to view what was happening on the unit from this central location.

5.2.3  Unit Staffing

Both the GU and MU were staffed primarily by RNs and LPNs who worked as general duty nurses with support from other nursing team members (referred to here as clinical nursing supports) and a range of other health professionals (referred to here as interdisciplinary clinical supports). I discuss each of these below.

5.2.3.1 General duty nursing staffing patterns

Regular daytime staffing on both units included four RNs and one LPN assigned to each 20-bed region. At night this was reduced to four RNs per region on the GU, and three RNs and one LPN per region on the MU. The GU also had two PCAs per 20-bed region 24-hours a day; the MU had one PCA assigned to the 40-bed region for an eight-hour night shift.

The PCAs on the GU were each assigned 10 patients and were responsible for the basic physical care of these patients and for answering call bells. The PCA on the MU was responsible for bathing as many patients as possible over an eight-hour night shift. This meant that they woke patients up to bathe them in the middle of the night.

There had been significant changes in staffing patterns on both units over the previous five years. The GU previously had six RNs with one PCA on both day and night shifts, and
nurses felt that their current staffing levels represented a significant reduction, even with the added clinical support of a discharge-planning nurse. In contrast, the nurses on the MU felt their staffing levels had improved with the addition of an LPN, although they continued to view their workload as challenging due to the increased complexity of their patients. LPNs’ scope of practice included the care of stable patients, whereas RNs’ scope of practice included both stable and unstable patients, and the complex patients on both units were more likely to be unstable, requiring the attention of an RN.

Another key difference between the two sites related to how patient care assignments were handled. In essence, patients were assigned by location on the MU and by medical acuity on the GU. The RNs on the MU divided the unit geographically into five or six patients each, and then each RN assigned the LPN one of their more stable patients. This meant that the LPN was the only nurse with patients located across the unit and he/she reported any patient care issues to four different RNs, because each of the LPNs’ patients was overseen by a different RN. It also meant that each RN was responsible for guiding the LPN with only one patient.

On the GU, patient care assignments were determined by the charge nurse according to acuity—the nature of the patient’s illness, the numbers of intravenous (IV) medications, and/or required complex medical interventions. Patients with less acuity were assigned to the LPN. As a result, nurses tended to have their patients located over a larger area. One RN was assigned to guide and assist the LPN with all his/her patients. This RN had a patient assignment with the same level of acuity as the other RNs, despite the added responsibility associated with assisting the LPN.
5.2.3.2 Clinical nursing supports

Clinical nursing supports were the personnel whose roles were to support nursing practice at the bedside and who were considered part of the nursing team. On both units, this included a unit clerk, a clinical leader, an educator, and a manager. Unit clerks were responsible for processing medical orders, coordinating information related to patients’ tests, admissions and discharges, and facilitating the exchange of information between all types of healthcare professionals. Clinical leaders were responsible for tracking patient care concerns, ensuring that patients moved through the hospital systems, and attempting to ensure there was appropriate staffing in place. The educators were responsible for supporting general duty nurses, especially around procedures that were either new or infrequent on the unit. The managers were responsible for the hiring and evaluation of staff, as well as the overall budget.

For the most part, the MU had fewer clinical nursing supports compared with the GU, which had a nurse responsible for discharge planning, as well an educator who was dedicated to the one unit. The educator for the MU was also responsible for five other medical units in the hospital, while discharge planning on the MU was carried out by the clinical leader in addition to her other duties. In both settings, the clinical nursing supports worked a regular weekday schedule, Monday to Friday.

5.2.3.3 Interdisciplinary clinical supports

Interdisciplinary clinical supports comprised physicians and allied healthcare professionals who were assigned to the nursing units. Nurses on both units worked with physical therapists (PT), occupational therapists (OT), rehabilitation aides, social workers, and dieticians. There were also physicians working on both units, although the staffing patterns were strikingly different. The MU was covered 24 hours a day, seven days a week by rotating hospitalists who
were employed by the facility to manage the medical care for patients admitted across the hospital. There were also consulting specialists who managed some of the patients on the MU. In contrast, the GU, as a medical teaching unit, was staffed by doctors at different levels of specialist training working together in teams. At any time, there were six teams working on the GU, each comprising four medical students, two residents, and a physician. In addition to these medical teaching teams, there were also consult teams associated with each medical specialty (for example, cardiology or neurology) with similar organizational structures. Every two months, the medical teams changed as the students and residents rotated to a different specialty. As a result, determining which doctor to call for a particular patient concern was complex. In general, nurses called the least experienced student doctor and if their call was not returned, or if they did not receive a satisfactory response, they would call a more senior student doctor. Since each of their patients could be assigned to a different team of doctors, nurses were frequently consulting a whiteboard on the unit, which provided information about the team assigned for each patient.

The availability of the interdisciplinary clinical supports varied. The allied health professionals generally worked on a regular weekday schedule, while the physicians provided coverage around the clock through an on-call system.

5.2.4 Hospital Systems

At both sites, structures and systems were generally organized so that most resources were available Monday to Friday during normal business hours. Managers, clinical nursing support staff, and members of the interdisciplinary team usually worked a regular weekday schedule, as did most staff members in the pharmacy, medical imaging, and laboratory departments. There were also fewer nurses working evenings and nights, even though older adult patients tended to be admitted during these hours. Although the staffing levels of the general
duty nurses remained the same seven days a week, these nurses had to assume many of the duties of the clinical leader and other support staff on the weekends.

Both sites were dealing with almost constant overcapacity, that is, being forced to admit more patients than their funding and staffing allowed. This meant opening rooms that were closed on the GU, or putting a patient in the hallway on the MU. Nurses on both units explained that they did not receive extra staff for having the one or two extra patients that were on their unit on a daily basis. One of the clinical leaders explained that the hospital received benefits if they were able to get patients into a hospital bed within ten hours of being admitted through emergency. She explained that hospital administration viewed accommodating overcapacity patients as a short-term solution to a hospital-wide problem.

While the GU had somewhat more space to accommodate extra beds, the nurses were still forced to find essential equipment when admitting overcapacity patients. Since the MU had less space overall, nurses were forced to move discharged patients out of their beds and into wheelchairs to wait for someone to pick them up in order to accommodate older patients being admitted from the emergency department.

Nurses on both the MU and the GU were also affected by overcapacity that could be occurring in other parts of the hospitals. For example, nurses explained how the pharmacy department could become overwhelmed when extra patients were admitted, especially during evenings and nights, and as a result it would take much more time to receive medications that had been ordered for patients on their units.
5.3 Conclusions

In this brief chapter I have described characteristics of participants in my study, and provided an overview of the settings in which the study was conducted. This included a brief description of typical patient populations and the physical environment of the hospital units as well as a description of usual staffing patterns and important system characteristics describing the way hospital processes and supports were organized. This description will serve as important context for the next chapter that describes the theory of orchestrating care.
CHAPTER SIX: ORCHESTRATING CARE

6.1 Introduction

The previous findings chapter has provided a description of the participants and the settings that provided the data for this study. In this chapter I present the theory I have constructed from my analysis of the data. This theory explains how nurses are symbolizing and enacting their practice with hospitalized older adults. As identified in earlier chapters, nurses are care providers who are regulated and licensed by a professional body (CNA, 2012). Although patient care aides (PCAs, who are unregulated care providers) were participants in this study by providing their perceptions of nurses and nursing care, this theory represents how registered and licensed practical nurses, (RNs and LPNs) who are responsible for directing patient care, managed their practice with hospitalized older adults. The key problem nurses were trying to solve was to provide good care while sustaining themselves as good nurses—the nurses they wanted to be.

Nurses described the weighty responsibility of caring for an older population with complex\(^{\text{13}}\) needs in hospital systems that they identified as ill-equipped to manage these complex needs. As a result, they characterized their practice as inherently hard, misunderstood, and inadequately resourced. As one nurse explained: “First line is always suffering. I would like to see my co-workers happy and healthy, and patients getting good care. It’s not a reality” (RN 13, Site 2). The nurses needed to orchestrate care to achieve their goals for patients, which they described as good care. They also needed to figure out strategies to sustain being the good nurses they wanted to be. In what follows, I will provide an overview of the theory of orchestrating care.

\(^{\text{13}}\) Complexity is defined as the degree to which a patient’s condition is influenced by a range of variables such as multiple medical conditions, impaired ability to make decisions, and challenging family dynamics (CNA, 2012).
followed by a detailed explanation of orchestrating care and the two subprocesses of building synergy and minimizing strain that comprise orchestrating care.

6.2 Overview of the Substantive Theory

Nurses were engaged in the continuous process of orchestrating care to resolve their problem of providing patients with what they perceived as good care while sustaining themselves as good nurses. Nurses symbolized good care as: keeping patients safe, individualizing care, enhancing patients’ function, and promoting comfort care at the end of life. They symbolized sustaining themselves as good nurses in terms of believing they did the best they could for their patients in difficult circumstances and had met the obligations and competencies specified for them by their professional bodies. Often that involved privileging patient safety, which they symbolized in narrow ways, over other goals of good care. To keep patients safe, nurses looked for allies as they developed their lines of action to resolve their problem. When they did not regard other care providers and leaders as allies, nurses turned inward for support from other nurses, in the hopes of relieving their feelings of being overwhelmed, pressured, ignored, and misunderstood. Turning inward to resolve their problem both aided nurses (by providing short-term relief) and inhibited them (by increasing their isolation) from achieving their goals of good care.

Orchestrating care is the core variable that explains how nurses are continuously trying to manage their work environment by understanding the status of their patients and their units, mobilizing the assistance of others, and stretching available resources to provide good care. Although there were times when orchestrating care was easier than others, it was an unending
process because of the unpredictable nature of caring for acutely\textsuperscript{14} ill older adults in the context of ever-changing acute care hospital units. Orchestrating care was enacted by all of the nurses; however, more experienced nurses used a broader perspective that took into consideration nurses, patients, families, and nuanced information about the status of the units. Orchestrating care subsumes the processes of building synergy and minimizing strain.

The category of building synergy is a subprocess of orchestrating care that explains how nurses leverage and share information, and gain the assistance of others to improve their odds of providing good care. Because nurses recognize they need information from a variety of sources and the assistance of others to orchestrate care, they are continuously building synergy to support orchestrating care. When nurses are building synergy they are doing reconnaissance, by constantly surveying and evaluating their patients’ health status and their available resources. They are passing information, by serving as a central conduit of patient-related information among patients, families, and members of the healthcare team. They are navigating relationships, by negotiating spoken and unspoken expectations about working with teams. Doing reconnaissance and passing information were supported by nurses trying to engage other healthcare team members and patients and families in their goals; however, when situations became complex and overwhelming, nurses relied more heavily on passing information between each other. At times like this, the non-nursing members of the team were seen as possible adversaries undermining nurses’ efforts to provide good care and sustain themselves as good nurses. Under those circumstances, members of the nursing care team emphasized their alliances with each other in trying to provide good care while sustaining themselves as good nurses.

The category of minimizing strain is the second subprocess of orchestrating care. It contributes to orchestrating care by explaining how nurses use available resources, rely on one

\textsuperscript{14} Acuity is defined as the severity of a patient’s condition (CNA, 2012).
another for guidance and support, and frame their practices in ways that create a supportive nursing network that makes it easier for them to believe they are providing good care, which in turn enables them to sustain their image of themselves as good nurses. Through the process of minimizing strain, nurses tell each other that they are doing the best they can in what they regard as impossible circumstances, and that their efforts in orchestrating care are supporting their aspirations to be good nurses. Minimizing strain enabled nurses to process their feelings about falling short in providing good care; they reframed their nursing care in ways that supported the goals good nurses would undertake. Nurses minimized strain by: maximizing resources, to creatively stretch available resources, such as time and energy; sharing experiences, to provide guidance and support to their nursing colleagues; and reframing the work, to interpret undesirable nursing care practices in positive ways. Minimizing strain provided a way for nurses to perceive they were providing good care and acting as good nurses, but it limited their perceptions of other options and allies in providing good care. In this way, minimizing strain interfered with nurses’ efforts at building synergy with individuals other than their nurse co-workers because they relied on each other so heavily for support, and often defined others as adversaries. Limiting building synergy with other healthcare providers, family members, and patients increased the likelihood that nurses would feel misunderstood, ignored, and inadequately resourced.

6.3 Orchestrating Care

The process of orchestrating care explains how nurses are continuously trying to resolve their problem of providing good care to patients while sustaining themselves as good nurses. To manage this they need to understand the status of the patients on their unit and the status of their unit, mobilize assistance, and stretch available resources. In what follows I will explain how
nurses symbolized good care and sustaining themselves as good nurses in contexts they perceived as ill-equipped to support their practice with hospitalized older adults. Nurses symbolized good care as keeping patients safe, individualizing care, enhancing function, and promoting comfort care.

*Keeping patients safe.*

Nurses identified keeping patients safe as their number one priority. Keeping them safe meant protecting patients from potential harms related to their conditions, the environment, or even other healthcare professionals. Nurses were most concerned for the safety of older adults who were physically unable to walk unaided, or who were in a state of delirium. They symbolized keeping these patients safe as preventing them from falling, or from interfering with equipment that was being used to treat a patient’s acute medical condition. To achieve this narrow definition of safety, nurses were often physically or chemically restraining these patients, thereby putting at risk the other goals they had identified as being part of good care.

The goal of keeping patients safe also included protecting patients from errors related to hospital systems or personnel. As one nurse explained: “If something looks fishy it is good to check. Sometimes an inexperienced nurse has misinterpreted an order or there are certain nurses that aren’t as diligent so we have to check carefully” (RN 3, Site 1).

In an environment where patients and staff were continuously changing, there was a constant potential for error. For example, when there were many doctors coming and going, and especially when they were writing orders around the time of the nurses’ shift change, it was more likely that these orders would be missed or misinterpreted. Nurses were accustomed to people

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15 Delirium is an acute confusional state caused by another medical condition (Amella, 2006; Barakzai & Fraser, 2008).
and systems falling short of what was needed to meet the needs of patients on their units, necessitating their vigilance to keep patients safe.

The importance of keeping patients safe was part of nurses’ socialization as professionals. An example of this was articulated by one of the participants. “I take the responsibility. This is under my license” (Bystander 2, Site 2). Institutions reinforced this belief with the “motto, safety first in this health authority” (LPN3, Site 2). Preventing falls as an important aspect of safety was reinforced within institutions through the need for nurses to complete paperwork if one of their patients fell, and through the constant reminders from posters on the units identifying the importance of fall prevention. Nurses symbolized keeping patients safe as critical to protecting both patients and themselves as good nurses; keeping safe was viewed by nurses as the most important goal of good care that they considered as they were synchronizing their lines of action to orchestrate care.

*Individualizing care.*

Individualizing care was another key goal articulated by all of the nurses. They were trying to adhere to principles they had learned in their professional nursing education, as explained by this respondent: “One thing about nursing that you’re taught is to go in and see the patient as a person. Everybody is unique and needs individualized care. It should be different for each person” (RN1, Site 1).

As this nurse and many other nurses explained, individualizing patient care for older adults required talking to them and their families and learning about their personal histories and preferences. Nurses symbolized individualizing care as providing their older adult patients with some choice around their activities of daily living, such as when they received their pills, or got out of bed, or had their hygiene care. These were the kinds of choices that could be offered
within the constraints of the organization; however, providing such choices was not completely motivated by altruism. Nurses were pragmatic, recognizing that these kinds of choices made it easier for them to do their work. As one nurse explained:

You’ve got to respect what they want done and when they want it done. It just makes it easier because you’re not pushing them to do something they don’t want to do. They do stuff at their own pace and you just got to let them do it. (LPN 1, Site 1)

This nurse explained how nurses were acting around how they symbolized individualized care. By providing patients with opportunities to choose when they would receive assistance, nurses would ultimately find less resistance from patients to their efforts to orchestrate care.

Enhancing function.

Enhancing function was regarded by nurses as assisting patients in progressing toward recovery and eventual discharge. Not only did the nurses see this goal as important for their patients to be successful following discharge from hospital, but the goal also fit with organizational expectations around moving patients through the system and out of the hospital. Enhancing function could include activities such as assisting patients to walk, or helping them in the bathroom. Nurses acknowledged the impetus and the need to enhance patients’ function to have them progress, but they also recognized that their strategies aimed at improving patients’ function had to be balanced with keeping them safe. One nurse explains:

It’s really touchy with the keeping safe and progressing because you have to always [be] keeping both of your eyes on the ball on both of them. When you are progressing them is too much then you are not keeping them safe. (LPN 3, interview 2, Site 2)

Nurses were negotiating enhancing their patients’ function, which was one of their goals and a defined goal of the system, within a hospital context that was not always a safe place for
older adults to increase their function. For example, the slippery hospital floors could be dangerous to older adults who were unsteady on their feet and could possibly fall and break a hip. Nurses were also aware that there were negative consequences for their patients if the nurses could not achieve a good balance between keeping safe and promoting function. As one nurse explained: “they get pneumonia because they’re not moving and they fall and they get an infection then they stay here and then they die” (RN 9, Site 1). This nurse’s explanation of common consequences for older adults arising from different nursing strategies demonstrates how nurses were acting to support their priorities; keeping patients safe by preventing falls was symbolized as the most important goal, despite the evidence that efforts to keep patients safe were undermining nurses’ goal of promoting patient function.

The impetus to promote older adults’ function came both from nurses’ belief that it was their professional responsibility to do so, and from institutional pressures to discharge patients as quickly as possible. One of the clinical leaders explained her role in encouraging bedside nurses to move patients toward discharge: “I’m trying to get the nurses, as much as possible, to take care of the sick patient, but also move patients forward. Weaning oxygen, getting them back to their baseline function” (Bystander 3, Site 2). Sometimes nurses experienced the pressure to “move patients forward” through imposed recovery trajectories in the form of generic care maps that had been developed for patients with a particular condition, but without taking into consideration co-morbidities, or age. Those maps suggested that patients should be ready for discharge faster than nurses explained was reasonable for the complex older adults on their units. This disconnect between the nurses’ goals for their older adult patients and institutional expectations that they saw as not taking account of the different needs of older adults contributed to nurses feeling overwhelmed and misunderstood and having difficulty in identifying allies.
Other evidence of institutional pressure aimed at enhancing older adults’ function was identified in posters hanging on the walls, as identified in the following field note.

In the conference room there is a big poster explaining how to do a mobility assessment and it says that mobilizing the elderly is everyone’s responsibility. There is also a poster on reducing falls stating a standard of mobilizing patients at least two times a day. (Field note, Site 2, December 20)

The posters I observed seemed to identify a particular definition of promoting function that did not take into consideration how mobilization might fit with other goals such as individualizing care or keeping patients safe. The posters also supported the pressure nurses described both to reduce falls (keep patients safe) and mobilize everyone twice a day.

*Providing comfort care.*

Providing comfort care was how nurses talked about their goals when caring for older adults who were near the end of their life. On almost every observation shift, nurses were discussing how to protect their dying patients from the suffering of unnecessary acute care interventions. They felt this was an important time in someone’s life that should be honoured. The nurses were expressing their agency by resisting interventions that were likely to increase the suffering of the older adult. As one nurse explained: “It’s the end of the life; it’s the finale, the death” (RN13, Site 2). Nurses wanted to smooth the process of death so that it was experienced as a comfortable transition by older adult patients and their families.

Nurses regarded comfort care as a goal that should take precedence over other goals when older adults were near the end of their life. Preventing older adults from suffering unnecessary interventions was a particular way of enacting nursing agency, both through meeting the goals of keeping patients at their end of their life safe and individualizing care for
what was considered important for particular patients and their families. When I asked participants about their most positive experiences with older adults, all but three told me stories of how their actions contributed to decreasing suffering at the end of life. The story that follows is an example of how nurses were realistic about the challenges they faced when a patient’s condition was changing, and doctors and families, as allies in meeting the needs of the patient, needed to be involved quickly. When things worked, the patient was made comfortable and the family was present.

I had a good look at him just coming up on the stretcher and thinking he’ll pass by tomorrow morning or the next day. He did not look good. He was suffocating in his own fluid. He was a mess. The orders were not very clear. I called the hospitalist. I was thinking there is more we can do. He needs to be comfort care. I called the family. The history notes said palliative but the [family] didn’t have a clue what was going on. I [said] to the doctors, you have to sort this out. I’m going to have to press the code button within twenty minutes. Long story short, it was a disaster. The doctor is taking his time with the chart and I was kind of wondering, what the heck is he doing, we’re going to have to call this code. Meanwhile the family is [asking] what’s going on? So then the doctor went through everything with the family. They were in tears, but they [asked] why didn’t anyone tell us? We made him comfort care. We followed the comfort care orders [and] he passed away at four that morning. I was really happy I followed my instincts and I made sure the family was coming in to say goodbye to their dad. (RN 4, Site 1)

This example highlights how nurses were enacting comfort care by using their agency to bring families and physicians together to understand the immediacy of death and to make the process of death a more comfortable transition.

*Sustaining themselves as good nurses.*

Sustaining themselves as good nurses was how I conceptualized nurses’ efforts to enact their practice by meeting professional competencies and obligations to their patients. If they
could achieve those goals, they could believe they were good nurses because they did the best they could in difficult contexts. Nurses viewed their practice as inherently hard, because they perceived challenges associated with caring for an older population and those challenges had to be managed in the context of hospital systems that did not support their work; instead of support, nurses felt their work was misunderstood and ignored. One nurse summed up the complexity of older adults, helping to explain why participants experienced caring for older adults as more challenging than caring for younger people:

Sometimes when you have one issue it unravels a whole bunch of other issues that have to be dealt with because you can’t just say here’s a bandage and out the door because they’re too vulnerable, too weak, they need more support. (RN 8, Site 1)

The complex issues associated with an older population required nurses to take time to sort out the issues and provide care that supported older adults and their families in hospital systems that were not designed to help them deal with patient complexity.

The system, it’s not set up the best for nurses. If the resource is not there for us we cannot do our best. It’s limited. It’s so limited. But each one of the nurses I think we are trying to do [our] best for the patient. (RN 13, Second interview, Site 2)

This nurse echoed many nurses’ comments about systems that constrained their ability to provide what they perceived as good care for patients and to sustain themselves as good nurses. Added to their perceptions of many challenges and limited resources was their perception that their efforts to try to put supports for their work in place were ignored or misunderstood because “nothing changes” (RN 10, Site 1)—they felt their voices were not heard.

Nurses’ abilities to sustain themselves as good nurses was under threat; they were overwhelmed by the responsibilities and expectations assigned to them by themselves, patients,
families, other healthcare providers and their managers. One participant summed up a common sentiment that nurses were “fully responsible”. “If you’re responsible, you have to be in control of the situation, because you’re ultimately responsible” (PCA 3, Site 1). Although they had a sense of needing to be in control of the circumstances on their units, the nurses found that trying to control all the elements in the care settings was impossible. In these all too common circumstances, nurses would focus on their most important goal of keeping patients safe and enact that goal in ways that were within their span of control.

The symbol of being under siege helps to conceptualize how nurses were symbolizing the healthcare system as the root cause of their problem. These system issues were identified as why nurses felt like they had to be in “survival mode” (RN 12, Site 2) in order to cope with the responsibilities, expectations, and misconceptions about the complexity and challenges associated with their work. Nurses explained how “survival mode [occurs because] I don’t have time” (RN 7, interview 2, Site 1) to give the best care. Survival mode was one way the nurses symbolized sustaining themselves as good nurses.

Sustaining themselves as good nurses required them to come to terms with the realities of nursing practice because “this is nursing now—it’s not going to change … It’s getting harder” (RN 11, Site 2). Nurses sustained themselves as good nurses through using survival language and by reframing the undesirable practices they engaged in while orchestrating care. By changing the language of undesirable practices, such as using physical and chemical restraints, nurses could conceptualize themselves as good nurses in challenging circumstances. In these ways, for better and for worse, nurses were influencing the way that nursing practice occurred on their units, which they spoke of in terms of how things were typically done on their units.
In summary, orchestrating care was the means by which nurses were managing their work as they struggled to resolve their problem of providing what they perceived to be good care while still sustaining themselves as good nurses. Orchestrating care occurred through the subprocesses of building synergy and minimizing strain. The pressure nurses experienced as a result of their responsibilities, the expectations they encountered from leadership, family, patients, and other healthcare providers, as well as nurses’ perceptions that their practice was misunderstood and the healthcare system was to blame for their problems led me to symbolize their practice as being under siege. The siege metaphor assists in conceptualizing orchestrating care as a dynamic process through which nurses developed lines of action around their perceptions of what was good care by good nurses.

Nurses enacted that process of orchestrating care through two subprocesses, each of which reflects a distinct pattern of nursing activity aimed at managing their problem. They built synergy by gathering and passing on as much information as possible about patients, families, available healthcare providers, and unit demands, and building relationships with others so they could achieve their goals. They used minimizing strain to maximize and access the resources that were available to them. Using resources effectively increased the likelihood that they could meet their goals. Relying on their allies for support and guidance aided in achieving their goals, but when others were identified as failing to cooperate with that process they could be characterized as adversaries; nurses reacted by turning only to each other for support. When all of those strategies were ineffective, the nurses reframed the work they were doing and the goals they were achieving so that they could sustain their views of themselves as good nurses. In what follows these subprocesses (identified in following diagram) and their properties and how they are interrelated will be explained.
6.3.1 Building Synergy

Building synergy is a subprocess of orchestrating care that explains how nurses gather information, share information, and work with others to assist them in resolving their problems of providing good care and seeing themselves as good nurses. It is essential that nurses have the assistance of others as well as information about their unit, patient movements and acuity in order to orchestrate care; their need for information and assistance leads to their efforts to be continuously engaging in the process of building synergy. Nurses described needing the help of others in many physical activities (such as turning patients in bed, or transferring patients from bed to chair) and many problem-solving activities, such as how to manage patients who are
critically ill, or who are exhibiting challenging behaviours. Nurses built synergy through their work with patients, families, and other healthcare team members in order to orchestrate care; however, if their allies failed them, there could develop a siege mentality. In that situation, only trusted members of the nursing care team were viewed as allies, and all others regarded as barriers to nurses resolving their problem.

Nurses found that when they were able to develop good relationships with patients, families, other nurses, and other healthcare disciplines, they exerted greater influence on others’ behaviours, which made it was easier for them to orchestrate care. Developing relationships was an essential part of developing joint lines of action that supported nurses in trying to control their work environments. Those environments could suddenly change due to the deterioration of a patient, sudden influx of extra patients, or a change in staffing patterns. Developing good working relationships was enhanced when nurses gathered and passed on information that helped patients, their families and other healthcare professionals understand patients’ conditions, and when nurses were able to trust the information they were receiving from others to assist them in orchestrating care.

Nurses’ ability to work effectively with others was also influenced by how they were navigating spoken and unspoken expectations about how to work with others. Nursing care teams and multidisciplinary teams were complex structures, constructed with a variety of roles (many of which were not clearly defined and were subject to change) and education levels, and working expectations that were not always clearly articulated. Nurses’ symbolization of these roles and how they responded to the symbols influenced how they engaged with others in ways that either constrained or facilitated how they orchestrated care. Building synergy was achieved through doing reconnaissance, passing information, and navigating relationships.
6.3.1.1 Doing reconnaissance

Nurses constantly did reconnaissance through ongoing assessment whereby they gathered information about the status of their patients, staffing levels, the physical environment of the hospital unit, and available resources. Doing reconnaissance was constant because the health status of the older adult patients and the acute care context were always changing; these constant changes required not only individual nurses but also the nurses together as a group to be ready to redefine their lines of action. Nurses identified the acute hospital context as in flux: “things change from hour to hour” (RN7, Site 1). The constant change meant that it was all too easy to make mistakes because something was “missed”, thereby putting their patients’ safety in jeopardy. A field note highlights the reasons nurses were checking carefully after the previous shift had experienced an influx of new patients with multiple doctors writing orders on several patients.

A nurse has come and talked to the RN about an order for a CBI (continuous bladder irrigation) that was missed. This is the second nurse to find orders that had been missed since the shift started two hours ago. The RN explains this is why she checks everything so carefully. “It is easy for things to get missed”. (Field note, Site 1, July 8)

Adopting a practice of constantly checking patients and the unit environments created circumstances where nurses could feel more confident that they were protecting patients from harm due to errors. They were expressing their agency to achieve a particular aspect of their goal of keeping patients safe. Nurses recognized the pressure to be vigilant in assessing patients and the unit environment under situations of constant change. This was akin to soldiers’ heightened attention to the possibility of disaster while under siege. Under pressure to be vigilant, nurses looked to one another for support, using language that positioned the healthcare system as the cause of their problem.
Doing reconnaissance was facilitated by nurses’ workday routines that provided opportunities to efficiently gather information for the purpose of assessing patients. The process of nurses assessing and judging the physical, cognitive, and emotional status of the patients on the unit began at the beginning of the shift during report when nurses read information about the care needs of their patients from the Kardex. Nurses took note not only of their own patient assignments, but also of the other patients on the unit. Their awareness that they might need to take the lead if any of the patients on their unit experienced a health crisis caused them to pay attention to the status of all the patients on the units. Nurses working on a particular shift were the team that would be orchestrating care for all of the patients on the units. Using information they gathered in the context of the report process, nurses developed their lines of action with their assigned group of patients and their joint lines of action to respond to the needs of the units.

Nurses incorporated doing reconnaissance continuously. While nurses at work might appear as if they were engaging in social conventions by chatting with patients and each other, they were at the same time observing and assessing at multiple levels. In a few brief social moments, nurses could note a patient’s colour, check their intravenous (IV), do a quick evaluation of their cognitive status, scan the room for safety hazards and emergency equipment, and determine who might be available to assist them. The more experienced the nurse, the more complex and nuanced was the assessment, evaluation, and prioritization occurring during their social interactions. One of the more experienced nurses explained:

Every time you go in the room you’re doing an assessment. Things can change quickly. They’re orientated but when you keep on talking to them you find that actually they’re not really with it. They’re odd or they have an odd behaviour and then you add that to your assessment because it’s ongoing. Every time you go there, you check. I’m looking at the patient, checking if he’s really independent to make [sure] that they’re safe. (RN 5, Site 1)
This nurse explained assessment processes that were used to determine if patients were developing delirium. Patients could seem orientated, but observation would help the nurse to decide if their cognitive processing was “off” and warranted further attention to determine if they were delirious. The complex nature of nurses’ assessments with older adult patients required looking for subtle changes in older adults’ cognitive or physical functioning; newer nurses had to learn these skills.

Some nurses, like the newer ones they’re overwhelmed. I used to be like that, there’s a point where you sort of stop and look at the bigger picture of things and you start caring about more than just the meds. (RN 12, Site 2)

This nurse explained that it had taken her about six months to gain the bigger picture of looking for subtle cues in her assessment of patients and how other experienced nurses stepped in to assist her. In this way, many of the nurses on the units—and in particular experienced nurses—were taking some level of responsibility for orchestrating care by assisting others in assessing the patients on their units. Without picking up on these subtle changes, nurses described having difficulty accessing other healthcare providers to assess and manage the acute problems of their older patients. Nurses needed detailed assessments to engage other healthcare providers in responding to changes in patients’ situations, and to understand themselves how to best keep their patients safe.

Doing reconnaissance also involved scrutinizing staffing levels in relation to the needs of the patients on the unit. To quickly determine if their staff mix had the right numbers and types of staff to meet the care needs of their patients the nurses relied on “shorthand” to describe their patients to each other and their clinical leaders. The best example was found in language that
symbolized the needs of patients through the terms acute and heavy. Nurses commonly used these terms to describe their patients.

Acuity referred to the complexity of patients’ medical status and the potential for their medical conditions to suddenly deteriorate. If patients were evaluated as being acute they required an RN to intervene and generate prompt responses in his/her interactions with doctors, managers, and other members of the healthcare team. Cues that would lead nurses to symbolize a patient as acute were the presence of tubes—such as intravenous and central lines, nasogastric tubes, and catheters—or patients requiring isolation procedures for an infectious condition. Patients who were considered medically stable but who could not be discharged because of their need for support in their activities of daily living (ADLs), or those who required comfort care were often described by nurses as heavy; they would receive less priority than those with acute needs. Cues that would lead nurses to symbolize a patient as heavy were dependence on nurses to be washed, mobilized, or fed; frequently these heavy patients were described as “confused.” Confusion was a term that nurses frequently employed to symbolize a decline in cognitive functioning; however, the term confusion did not differentiate between acute confusion (delirium) and chronic confusion (dementia).

Shorthand descriptions of acute and heavy provided nurses with information they used to construct their patient care assignments. For example, heavy was used to represent the idea that patients were occupying an acute care bed while they were waiting to go somewhere else, often a subacute unit or a nursing home. They were understood as having primarily functional needs, and even though these functional needs could be a symptom of an underlying acute illness, heavy patients were assigned to LPNs with PCAs providing basic physical care. Their care was given less priority by nurses than patients who were labelled as acute.
Nurses enacted orchestrating care in ways that meant heavy patients were less likely to be mobilized because nurses put priority on needs of patients they viewed as more acute. However, at the same time, the nurses believed that these practices often led to poor outcomes for such patients. One nurse explained: “They don’t get better care, they get bed sores, they get infections and they get actually worse in the hospital and [they end up] staying for quite a while” (LPN 3, Site 2). These were outcomes described by nurses that indicate reduced function and lack of individualized care, which constitutes failure to provide good care as the nurses defined it. Moreover, nursing care that contributed to patients staying longer in hospital beds did not support nurses’ responsibilities toward institutional priorities to discharge patients as quickly as possible. When patients stayed longer in the hospital, the numbers of patients waiting in the emergency department for a bed increased, which in turn led to nurses having to admit patients that exceeded their funding and staffing capacity. Those circumstances further contributed to their feelings of what I am symbolizing as being under siege.

Using language like heavy in contrast to acute to organize staffing patterns influenced nurses’ perceptions about older adult care. The symbol of heavy was used to characterize caring for older adult patients in general. One nurse explained: “They are heavy. [You] need time, patience to toilet them, give medications and they would like to chat with you” (RN 5, site 1). Nurses reported that they were “given the same amount of people” (RN 1, Site1) as were units with predominantly younger patients, even though they argued that older people took more time. Unfortunately, their effectiveness in convincing management that they needed more staff to safely care for these heavy patients was undermined by their shared assumptions about older adult care and nursing work, symbolizing older adult care as “not very acute” (RN 9, Site 1), consisting of “bedpans and pills” (RN 4, Site 1).
Nurses’ attempts to request more nursing staff had regularly been rejected; in some circumstances, nurses had to provide detailed explanations about why they needed more help to justify their need for more nurses to care for heavy older adults. One of the nurses explained: “In terms of asking for extra help, we all feel reluctant. We feel scared because it’s going to be looked at like why can’t you do it yourselves? ” (RN12, Site 2). This comment reflects nurses’ perceptions that part of fitting with others’ expectations of good nurses was being able to do it all without asking for more help. Nurses indicated that their nurse leaders valorized the efficient nurses who were able to work within the existing resources, thus contributing to how nurses constructed themselves as good nurses.

Although nurses identified particular levels of staffing as requisite to orchestrate care to meet their goals, they also recognized that “the budget is so tight you really have to put a really good case forward” (RN 11, Site 2); the only way to convince others to increase staffing was to argue that patients were at risk of injury without more staffing. That line of argument contributed to nurses’ narrow definitions of providing good care to keep patients safe. Beyond risk of harm, nurses were aware that an extra nurse could also walk patients, thereby enhancing function. In this way, higher staffing levels had the potential to meet two goals of good care—keeping safe and enhancing function. However, nurses reported that it took considerable effort to make the case.

Using the symbol heavy to differentiate members of the older adult population without specifying their needs inhibited nurses’ abilities to articulate their rationale for increasing staffing resources. Inadequate staffing levels both contributed to nurses’ challenges in orchestrating care to meet their goals for the patients on their units and their challenges in
sustaining themselves as good nurses, because they felt their efforts were not being supported and they could rely only on each other.

As part of doing reconnaissance, nurses continuously assessed the whole unit; they needed to know which nurses might need more help. They also needed to be aware of the presence or absence of essential supplies and equipment, and of the availability of help should they require it. An example of this was evident on one of my observation shifts with a new nurse.

The RN is making many steps back and forth to do the vital signs and assessments on her patients. The nurse that has been introduced as her buddy nurse is asking her if she is okay. Across the unit, two other nurses are watching this nurse as she goes about her work. (Field note, Site 2, November 7)

As the day progressed, the two who were watching the new nurse identified themselves as experienced nurses. Together with the buddy nurse they monitored how others, and especially new nurses, were contributing to the nursing team. Thus, they incorporated assessing how nurses were managing as part of their overall assessments of the unit.

Nurses evaluated changing circumstances on the unit to determine how staffing needs were changing. For example, the addition of critically ill patients, over census patients (patients above their funded beds), changing functional needs of older patients, or changing staffing patterns could affect their efforts to orchestrate care. Most of the nurses assessed their units, but more experienced nurses were more likely to engage in a nuanced approach to this type of reconnaissance, whereby they attended to many details. Newer nurses required time to adopt nuanced unit assessments; their learning curves placed greater responsibility on experienced nurses.
Nurses’ abilities to engage in doing reconnaissance were aided by the relationships they developed with other nurses, patients and their families, and the range of healthcare professionals they encountered on their units in their day-to-day work—unit clerks, doctors, occupational therapists (OTs), physical therapists (PTs), dieticians, social workers, and respiratory therapists (RTs). Without good working relationships with others, nurses could not utilize others selectively or effectively as they were orchestrating care. For example, a good relationship with the PT could result in a detailed plan for enhancing a patient’s function or to access mobility aides. Unfortunately, nurses did not consistently view relationships with other healthcare professionals as helpful, which affected their abilities to build synergy (especially through passing information) and minimize strain. At times, nurses associated their workload pressures with other healthcare professionals as “getting us to do their jobs. They are delegating it to us” (RN 2, interview 2, Site 1). Many nurses objected to other healthcare professionals’ expectations that they walk patients even though nurses identified that mobilizing patients was one of the ways they could achieve of their goal of enhancing function. Viewing other healthcare professionals as adding to their challenges limited nurses’ abilities to use partnerships to effectively orchestrate care because nurses did not perceive them as allies. In order to be doing reconnaissance nurses needed an understanding of the availability of other healthcare professionals, ways these professionals could be utilized, and how these professionals’ expectations about the types of activities nurses should be engaging in differed from nurses’ priorities.

6.3.1.2 Passing information

Passing information enabled nurses to obtain and share pertinent information that supported their complex lines of action for orchestrating care. Nurses served as conduits of
patient care details for patients and their families, each other, other members of the healthcare team and hospital departments. Access to such information aided nurses in combining their assessments of patients, staffing, and their units to orchestrate care. One of the participants identified effective communication as supporting the smooth running of good units: “If everybody is just doing their own thing, it’s mayhem. On a good unit everybody knows what’s going on. Everybody communicates” (PCA 3, Interview 2, Site 1).

Open communication not only enhanced trust among the nursing team members by providing the opportunity to understand other perspectives about particular interventions with patients, but also enhanced nurses’ working relationships with patients, families, and other healthcare professionals. Nurses recognized that good communication, while often challenging to achieve, was an essential element in their effectiveness in orchestrating care.

Nurses used good communication to achieve better cooperation from patients and their families, who were thought to be more likely to follow nurses’ requests if they understood why things were being done. They also recognized that listening to older adult patients’ and their families’ priorities enabled them to “get that helping relationship going [and] once you have that it’s easy” (LPN 3, Site 2). Nurses felt that listening increased their effectiveness as a conduit of information between patients and families and other healthcare professionals, which in turn supported their efforts to reach their goals, and get patients and their families onside to facilitate orchestrating care.

Nurses relied on communication tools to aid them in passing information. Nurses did reconnaissance through the report process, and used the Kardex to focus and pass information about their patients to one another. Because the Kardex was an important object used to
communicate efficiently with the rest of the nursing team it was problematic if the Kardex was not up to date. Unreliable information undermined doing reconnaissance and nurses’ efforts to develop their lines of action effectively and efficiently to orchestrate care. For example, lack of information on the Kardex created a challenging situation I witnessed during participant observation with one of the RNs.

In the middle of the morning a patient transport arrived to take one of the RN’s patients, who was receiving an administration of blood, to a nursing home. The nurse checked the chart to see if there was a discharge order, said ‘there is no discharge order,’ and she sent the transport person away. A few minutes later the discharge-planning nurse came onto the unit. The nurse asked the discharge-planning nurses about the transport that had arrived earlier. After this conversation, the RN explained to the other nurses that the possible discharge of this patient had been discussed with the nurse who had been caring for this older woman the day before. This information had not been entered in the Kardex. The RN spoke to the other nurses about the importance of information being written in the Kardex, as it was their primary communication tool. (Field note, Site 1, August 11)

When nurses had to spend time seeking information that should have been in the Kardex, it undermined their abilities to orchestrate care, in part because it interfered with both their efforts to meet their patient goals and their efforts to sustain themselves as good nurses. Days were organized differently if patients were to be discharged; physicians needed to be alerted to review patients’ charts and write discharge orders first thing in the morning. Failure to communicate important information through the Kardex reduced nurses’ time with other patients, which meant they might do less thorough assessments, resulting in less individualized care, and less attention to care that focused on enhancing function – two of their primary goals.

All participants symbolized the Kardex as critical to communication, despite their acknowledgement that it was not always reliable. On night shifts, I observed RNs carefully
reading charts and updating the information in the Kardex so that activities during the day would run more smoothly. Attention to the Kardex depended on adequate time to check charts during the night. Doing reconnaissances about staffing levels and the unit could provide nurses with information about whether the institutional context provided opportunities to support their critical communication processes, and thereby orchestrate care.

At the desk the nurses are checking the Kardex, writing down information about their patients. The nurse is writing down patients’ diagnosis, how patients mobilize, what tests have been ordered, the patients’ diets, what tubes are in the patient, how often to check their vital signs, and any recent doctor’s orders. (Field note, Site 1, October 25)

If the nurses did not consider the Kardex reliable, considerable time was taken to fill in missing elements critical to developing their lines of action and orchestrating care. Nurses regarded the report process as an important opportunity to try to fill in missing information. These instances highlighted the importance of passing information in developing an appropriate plan of care for patients. It also helped to explain why nurses were vigilant in doing reconnaissances. They found that assessing patients, staffing levels, and their units in anticipation of constant change was difficult if they did not have the information they needed.

Nurses were frequently observed conveying patient care details to their nursing colleagues. For example, registered nurses communicated with PCAs to ensure they were attending to patients’ levels of functioning, ways of enhancing functioning, and potential areas of risk.

After report the RN talked to the PCA about two of her patients that he will be washing. She explains to the PCA what she has learned from report about their new patient. She explains that the patient will require complete assistance with his care and that the patient’s son will bring in a specialized wheelchair. (Field note, July 16, Site 1)
Failure to convey critical information to PCAs could result in lack of mobilization and increased patient risk for infection and bedsores. Doing unit reconnaissance enabled the RNs to incorporate PCAs’ activities during report when the PCAs might be missing this information.

However, there were also many instances where nurses did not communicate with the PCA. One night I noticed that the PCA I was observing seemed to be watching and listening (from a distance) to the conversation between two RNs while he was engaged in other tasks. After the RNs’ conversation, he noted to me that a particular patient was going to continue putting the call bell on because the nurse had to call the doctor for an order for pain medication. In the conversation that ensued I learned that the PCA had answered the patient’s call bell several times and each time had communicated to the RN that the patient was requesting pain medication. The RN did not communicate to the PCA why she did not respond to the patient’s request. So the PCA was listening to the RN’s conversation in order to learn information that could be relayed to the patient if he called again. If the PCA knew the RN was working on resolving the patient’s concern, reassurance could be given when the patient called. The PCA explained that this indirect method of gathering information was a common experience and was necessary in order to provide reassurance to patients’ concern. Unfortunately, these kinds of situations where nurses did not pass information to the PCAs constrained their abilities to build synergy and to orchestrate care.

While nurses focused mostly on passing information among themselves and other members of the nursing care team, they also accessed information so they could pass it on to the most appropriate healthcare professional or staff in another hospital department. To do that, they had to make a judgment about the implications of what they had learned for their goals for
patients. The participant observation below provides an example of how a nurse recognized risk for infection and shared information with the appropriate healthcare professional.

The RN finds a computer and checks her patients’ blood work. She tells me that one of her patient’s white counts is elevated from yesterday. She explains that she will flag the doctors to see if they want to order an antibiotic. She writes a note to the doctor and puts it on the front of the chart. She explains that if the doctor doesn’t come in a couple of hours she will page the doctor about the abnormal blood work. Later the RN tells me that she called the doctor about a critical lab value. (Field note, July 16, Site 1)

Doing reconnaissance of the units also enabled nurses to identify patterns in other healthcare providers’ movements and activities, which facilitated timely communication of problems and enhanced achievement of goals as part of orchestrating care. Nurses’ well-developed communication styles also provided opportunities for them to advocate for their patients with doctors. They conveyed information to guide doctors (especially novices) to write orders to support nursing goals, such as comfort care orders with an older patient. For example, during an observation shift an RN caring for an older man who was not responding to the acute treatment plan called the medical team to reassess the patient.

The medical student and the junior resident are looking at the chart. The nurse says to me ‘indecision there’, going on to explain: ‘If it were a hospitalist or a doctor they would know what to do. I don't want him [the patient] to be tortured with another IV and deep suction and then he dies anyways.’ She explains that these doctors have not had the courage to tell the family that the wisest course of action is comfort care, that no matter what heroics they undertake he is unlikely to have a good response. (Field note October 25, Site 1)

Nurses advocated for patients by alerting physicians and presenting information about the patient and the family in ways that made it apparent that comfort care was required without actually directing physicians. Through passing information in this way, the nurses were
orchestrating care that fit with their goals of good care and that sustained their views of themselves as good nurses.

Nurses indicated that they were frequently admitting patients to their units with little to no communication from other units or clinical leaders; these circumstances contributed to their feelings of lack of control over their work environments. Orchestrating care under circumstances with limited communication contributed to nurses’ perceptions that only nurse co-workers could be considered allies. Orchestrating care under such circumstances also contributed to nurses’ perceptions about their role as just “a pair of hands” (RN 7, Interview 2, Site 1), which undermined their efforts to view themselves as good nurses.

6.3.1.3 Navigating relationships

In navigating relationships, nurses negotiated spoken and unspoken expectations about working with members of the nursing team and other healthcare disciplines to provide better patient care. They purposefully developed relationships with nursing colleagues and other disciplines to leverage support so they could orchestrate care more effectively. Nurses developed relationships with other nursing team members by carefully listening to them, sharing personal aspects of their lives, and offering help. Navigating good working relationships with others—in particular other nurses—fostered a sense of cohesion that was critical to orchestrating care. Nurses required confidence that, on those occasions when immediate assistance was critical, other nurses would assist with their patients. Orchestrating care in difficult contexts with limited resources and access to information required nurses to identify who they perceived to be “on their side” (other nurses), who among other healthcare professionals could be considered as allies, and who were more likely to act as barriers to the nurses achieving their goals.
Fostering and maintaining good working relationships required nurses figure out how to best work with a constantly changing cast of team members. All of the participants agreed that sharing the work and contributing expertise to the goals was essential to orchestrating care to meet their goals of good care: “[When] everybody works together and knows their job, [it’s] nice and smooth, everybody’s happy” (PCA3, Site 1). Unfortunately, nurses indicated that there was a lack of consistency in nurses’ and other professionals’ personal work standards to the point where “who you work with matters” (RN5, Site 1). Nurses compensated for variability in work standards, staffing, patient acuity, and unit functioning by developing trusting relationships with nurses with whom they worked most frequently; when they found a good team, they stayed. “I like how we work together so that’s why I’m staying” (RN 10, Site 2). In questioning nurses about what was good in their working relationships, they indicated that working with “good helpers”—defined as those who would anticipate and help without being asked—was what made these working relationships good (Field note, July 2).

An important aspect for nurses to navigate relationships was learning about who to trust. They came to know this by listening to others and asking questions about others’ work background as well as their personal lives. With trust, nurses had more comfort in sharing information, and seeking and offering help. For example, when the nurses learned that someone had worked in intensive care in the past, they would go to this individual with questions about their unstable patients. Trusting relationships were often developed by being together in challenging care situations and working out possible solutions, especially in situations when they had only each other to rely on for help.

Nurses fostered the process of getting to know and trust others through the sharing of food during breaks and on night shift. Sharing food was more than a gesture of good will. Over
food, nurses could develop complex interconnected relationships that were foundational to creating synergy and minimizing strain in orchestrating care. Sharing information about themselves enabled nurses to learn about each other’s values, different practice challenges and their possible solutions. The sharing started with personal experiences, which provided a basis of trust to share past challenging care situations, what they did in response, and their regrets over situations that had not gone well. Other nurses would offer alternative strategies to manage the situation. In these ways, nurses shaped the nursing care on their units through personal relationships.

Nurses’ abilities to develop trusting relationships beyond the nursing team were complicated by the Monday to Friday working hours of other healthcare professionals. Most professionals, such as OTs, PTs, dieticians and social workers, did not work around the clock and on weekends, in contrast to nurses’ work patterns. Other professionals were not attached to the same units for their entire workdays and did not share the same staff room (a place where many social connections occurred). Thus, nurses’ interactions with other healthcare professionals were usually brief and focused on specific patient concerns. There were fewer opportunities for nurses and other healthcare professionals to develop trusting relationships, such as those between nursing staff members. This was particularly the case on the GU where student doctors at all educational stages rotated through the unit every two months. There was not always enough time to become familiar with the other healthcare professionals, which limited nurses’ understanding about how to work with and trust them in order to leverage better care.

Frequently, nurses identified other healthcare professionals as barriers to good care (not allies) on the basis of past interactions where nurses felt other professionals were directing their work without any understanding of their work or priorities. For example, nurses reported that
some PTs expected patients bathed by 8 a.m., when nurses were busy trying to administer medications and feed patients breakfast. In particular, nurses regarded their exclusion from care planning meetings as an indication that their contributions to patient care were not valued by others, which undermined their efforts to regard themselves as good nurses. As one nurse explained:

We have virtually very little say and we have something called care planning meetings, that nurses were not invited to attend. The nurse is the lowest on the totem pole, so all this planning—what is good for the patient, what is not good for the patient—has been taken away from us. (RN 7, Interview 2, Site 1)

In addition, nurses perceived that their contributions were undervalued when doctors’ views were given precedence over nurses’ assessments and evaluations, particularly when nurses were doing reconnaissance in many areas of which doctors were unaware. One nurse said: “We accommodate the doctor. It is the hierarchy and it just has to be” (Field note, July 16, Site 1). When there were unequal power relationships that affected nurses’ lines of action, they indicated they did not completely trust other healthcare professionals. Lack of trust limited nurses’ willingness to engage in open communication and serve as a conduit for information, which negatively affected their efforts to orchestrate care.

Being part of the nursing team was critical to orchestrating care. Nurses regarded care of older adults as a team activity because of the requirements for physical assistance with managing patients and assistance with problem-solving challenging patient behaviours, usually due to delirium. Trusting relationships with other nurses not only facilitated being part of a nursing team, but also increased the likelihood of reciprocity, which was key to being a good team member. Being reciprocal in extending help to others was viewed as a sign that nurses
understood the need to give and take. Nurses who made efforts to be helpful were rewarded by receiving assistance in return: “When I do it [answer other nurse’s bells], those nurses tend to do my bells too. It’s give and take. It’s more give and take when you do that” (LPN 3, Site 2).

A nurse who was new to the unit and the profession was able to articulate how learning to be a team player was essential to be accepted as part of the nursing team. She identified failing to engage in reciprocity as leaving nurses without help in difficult situations when they required assistance with care or emotional support.

If you’re not really a team player, your life is going to be miserable. On any unit, it’s hard. Even in terms of support, like you’re having a bad day. And then you’ve got nobody to talk to. Nobody to answer your call bell. (RN 11, Site 2)

Fitting into the nursing team could be challenging because it was not easy trying to initiate trusting relationships with members of closely knit teams. This new nurse put it this way: “Crews start working together and it’s a way of bonding through hardship. But also it can be limiting and alienating for others coming through” (RN 11, Site 2). With the support of team members, orchestrating care was more likely to result in good care. Unfortunately, helping others could be challenging for new nurses who were having trouble effectively managing the care of their own patients. One nurse who was able to reflect back on her growth as a new graduate explained that they “gave new nurses some slack” (RN 12, Site 2) in demonstrating their worth as a team player.

Nurses symbolized good helpers as anticipating the needs of others, frequently assisting others in the absence of requests, and willingly giving assistance when asked. One nurse explained: “people that will listen to you and help you out, trouble-shoot with you, go out of [their] way” (RN 7, Interview 2, Site 1). I observed individuals who were identified to be good
helpers sharing their skill and expertise, for example by starting an intravenous line, or providing interpretation for patients who did not speak English. I also noticed that RNs, LPNs, and PCAs would assist others with admitting a new patient, preparing to receive extra patients, and helping out with an urgent or emergency situation. Helping one another with patient care was seen as more important than the paperwork associated with charting and taking breaks. This was because orchestrating care for all the patients on the unit was viewed as nurses’ joint lines of action. Charting was an individual act that could be completed after the end of the shift when a group of new nurses was attending to patients’ needs.

Nurses did not have the same expectations of other healthcare professionals. These different expectations partly resulted from the others’ lack of availability, and partly from their sense that others did not appreciate nurses’ knowledge about the patients, staffing levels, and units. Nonetheless, it was more difficult to orchestrate care effectively to meet goals when nurses did not include other healthcare professionals as part of their team.

Nurses’ perceptions about roles and expectations within the nursing care team also helped to guide joint lines of action toward effectively and efficiently orchestrating care for all of the patients on the nursing units. Even though it was not possible to totally control their work environments, experienced nurses felt responsible for newer nurses or nurses who were unfamiliar with the units. The RNs in particular were viewed as ultimately responsible for orchestrating care for all of the patients on the unit; during my participant observations I saw more experienced RNs scanning individuals and the unit for potential problems. In particular, they watched casual or less experienced nurses to determine how they were managing. One of these nurses explained why.
If one nurse is suffering then all of us are suffering because that one nurse is not happy and she’s not getting her stuff done and she’s stressed out. My concept of nursing is teamwork, your strength is your weakest link. (RN 7, Site 1)

To effectively orchestrate care in the context of changing unit conditions, the synergic effect of a well-functioning team was especially important in situations where one of the players was struggling. Within the team, it was expected that newer nurses would ask more experienced nurses for their opinions about care and for reassurance that they had done or were planning to do the right thing. One nurse said: “If I feel uncertain about some things, I always go to a nurse, older usually, that’s more experienced, and make sure that I’m following good practice” (RN 4, Site 1).

When newer nurses asked those with more experience for advice, they were provided with both reassurance and unit-specific strategies about how to approach care in challenging contexts, such as the care of confused older adult patients. If the newer nurses did not ask questions, the experienced nurses would question them until they were satisfied that the novices knew enough to ask for help when needed. When I was observing a new nurse I saw examples of these behaviours. Eventually, these newer nurses were able to learn to see how their patient care assignment fit with the care of all of the patients on the unit and were able to take a more active role in developing joint lines of action. They were able to be one of the nurses who helped others without being asked. One nurse explained how she learned about how to help others from her experiences of being helped as a new grad: “If I’m working with nurses that will help me out, [if I am busy] they might start giving medications for other patients, so I feel obligated to help these girls out” (RN12, Site 2). As part of orchestrating care, experienced nurses viewed time helping newer nurses as an investment in nursing resources that would be paid out to many other nurses.
in the future. These experienced nurses were also modelling a particular representation of nursing teamwork and about how things were to be done on their units.

The nature of nurses’ formal roles or scope of practice also influenced how they worked together to orchestrate care. The RNs explained that LPNs had more stable patients (patients who were less likely to experience a life or death crisis), as was fitting with the LPN scope of practice, and it was the RN with a more acute patient load who often had to help the LPN. One RN explained the type of activities for which LPNs required their help: “LPNs ask frequently questions or they solicit assistance with medication sometimes. Hanging IVs, antibiotics, starting saline, inserting access, peripheral access IVs, questions about medications” (RN 3, Site 1).

As part of navigating relationships, LPNs were expected to ask for help when they were uncertain about anything related to patient care. The RNs perceived this kind of helping as unidirectional, disrupting their assumptions that help should be reciprocated. The RNs could be overwhelmed when they had to assume care for LPNs’ unstable patients, in addition to their own acute patient assignments. The RNs’ patients were generally acutely ill, which resulted in no opportunities to shift the work assignments to give LPNs less acute patients.

There were also differing perceptions about the roles of members of the nursing team. Some RNs believed that PCAs could make a bigger contribution to mobilizing older adults, and some PCAs believed that RNs and LPNs could contribute more to the personal care needs of their patients. In other words, they were not consistently comfortable with the division of labour within the nursing team. One RN explained:
Their [LPNs’] patients are people who are stable and that creates a lot of conflict [because RNs] have the acute patients but they also have a lot of the heavier patients with tube feeds or some of the sick ICU patients. (RN12, Site 2)

Conflict arising from team members’ perceptions that LPNs could be doing more to help the RNs with the patients on the units, or that care aides could be more active, undermined nurses’ efforts to orchestrate care to achieve their goals.

6.3.1.4 Summary

Nurses were engaged in the continuous process of building synergy to orchestrate care because they believed it increased the likelihood of providing good care for their patients while still sustaining themselves as good nurses. Nurses explained the importance of working with patients, families, and other healthcare team members to orchestrate care. In practice, because they could be overwhelmed by expectations from all of those groups as well as from their own nursing leadership, trusted members of the nursing care team were represented as allies, while others could be viewed as possible adversaries to nurses’ efforts to provide good care. Nurses’ symbolization of a healthcare hierarchy with doctors and other healthcare professionals at the top, directing but not supporting the work of nurses, influenced their interactions beyond the nursing team, ultimately diminishing their effectiveness at building synergy as they were orchestrating care. Resentment about unequal power arrangements and diminished trust with other healthcare professionals contributed to nurses’ perceptions of the nursing care team as the main resource in orchestrating care.

Within the nursing team, symbolizing reciprocity as being a good helper and team player aided nurses in building synergy to orchestrate care. The time taken for nurses to learn how to help each other, and the resultant challenges to reciprocal relationships in nursing teams that
included nurses with a variety of educational levels and roles, could create conflict among the nursing team members. Varying roles within the nursing team influenced how effectively information was passed and how broadly reconnaissance was enacted. Ultimately, RNs had the largest share of the responsibility in doing reconnaissance, passing information, and navigating relationships; more experienced RNs shouldered more responsibility than novice nurses.

In addition to building synergy, the nurses used minimizing strain to orchestrate care. Minimizing strain incorporated strategies for nurses to provide good care to their hospitalized older adult patients while still sustaining themselves good nurses.

6.3.2 Minimizing Strain

Nurses were engaged in the continuous process of minimizing strain so they could orchestrate care. They minimized strain by making the most of their available resources, supporting and guiding one another, and reframing their practices in ways that created a supportive network to provide good care and sustain themselves as good nurses. Nurses demonstrated their agency through the creative extension of time and physical resources when they orchestrated care. Their reliance on each other for support and guidance could undermine their engagement with other healthcare providers and patients and families. Reframing involved telling each other that they were doing the best they could, under impossible circumstances by focusing on keeping patients safe even when they abandoned other goals they associated with good care. In so doing, they were trying to sustain themselves in their own eyes and the eyes of administrators, as good nurses who encountered obstacles to orchestrating care.
6.3.2.1 Maximizing resources

Nurses maximized resources by engaging in creative ways to extend their physical resources and time. For example, many of the nurses engaged families as resources. While some nurses clearly viewed families’ questions about patients and expectations for patients as contributing to the pressure nurses experienced when trying to orchestrate care, half of the participants viewed families as valuable resources in aiding nurses to better understand their patients and their patients’ needs. With families contributing, nurses were more likely to individualize patients’ care and improve patients’ functioning. In an observation shift with one of the RNs, I noted that she took considerable time talking to families of her older adult patients.

She explained that she spent time talking to families and encouraging them to visit with patients because she found that patients were calmer with the family present. She pointed to a chair that would fold out as a bed that to allow family to stay the night. (Field note, Site 1, July 16)

Nurses often encouraged family members of older adults who could not speak English to stay as long as possible to interpret for the patients. They also noted that disoriented patients found family members’ presence orienting and comforting. Families were used as resources in helping nurses assess and comfort patients and evaluating their success at achieving their goals. This could contribute to nurses feeling like they were getting closer to providing good care by using families in strategic ways.

Nurses extended their abilities to access resources through creating a supportive network of nursing allies who had good knowledge of the hospital and hospital systems to support their efforts to orchestrate care. These allies aided one another in problem-solving where to find equipment, or basic supplies like food, particularly during evenings and weekends. At those times, other departments were either closed or operating with minimal staff because hospitals
were “24/7 facilities that run Monday to Friday” (Bystander 4, Site 1). The current organization of hospital systems and other healthcare professionals’ work contributed to nurses’ sense that they could only rely on each another. Frequently nurses would ask each other if they knew the best place in the hospital to find food, an intravenous pump, or other equipment. I followed one nurse to three different units until she was able to find some food for her hungry patient. The nurses on her unit and on other units offered suggestions about which units might have some food. On another night shift, I observed a nurse eventually purchasing food for her hungry patient—with her own money—out of a vending machine in the cafeteria.

Nurses would frequently “borrow” resources from other units in their efforts to meet patients’ needs. For example, in absence of supplies on their unit, they would take a washbasin from another unit (although this practice could, of course, leave other units short of equipment).

An example of this dynamic is in the following field note.

Many nurses are discussing the need for a chest tube insertion tray for an older adult patient. The nurses are discussing that central supply is not responding to the messages they left requesting the chest tube insertion tray. A nurse suggests that the central supply room must be closed for the weekend. Another nurse identifies that this procedure appears to be diagnostic rather than related to an urgent need. Another nurse reports that on another unit in the hospital, where she used to work, this tray is a stock item. She volunteers to go up to the unit and ask to borrow the tray.

(Field note, Site 1, July 1)

Nurses consistently used each other’s knowledge of hospitals to find the resources they needed. They did not undertake searching for equipment or other resources lightly. For example, they discussed needs in the context of the purpose of the procedures and possible detriments to patients’ medical care if procedures were delayed. Their conversations demonstrated multiple perspectives about procedures, locations of necessary equipment, and best approaches to
obtaining equipment. Nurses identified the utility of sending someone who knew nursing staff in other locations to explain why they needed equipment; they were trying to use their allies. Relationships nurses had developed in building synergy could be helpful to them when they were maximizing resources.

Nurses could perceive other healthcare professionals as adversaries to their efforts to minimize strain and orchestrate care if they undermined access to necessary equipment, even if unwittingly. For example, a locked equipment storage cupboard with therapy staff (OTs and PTs) controlling the keys could prevent evening or weekend access to special equipment that made mobilization possible. Such events undermined nurses’ efforts to orchestrate care to promote patients’ functioning, one of their important goals.

The challenges nurses were facing in trying to find basic necessities to orchestrate care, such as food or equipment, contributed to their view that they were overwhelmed and on their own. It was commonplace for nurses to search for basic equipment, such as intravenous (IV) poles, blood pressure machines, basins to wash patients, and urinals. Spending time searching for basic resources used precious time and energy that was unavailable to build synergy through doing reconnaissance and to provide direct care to patients to meet the goals the nurses wanted to achieve. One of the participants described the daily struggle to obtain basic supplies and equipment:

That wastes a lot of time looking for urinals or anything. It takes at least 2 or 3 minutes out of what you are doing. A small thing that we could just be handed, but it’s not. It is something that you struggle for many times throughout my shift for getting the resources. I have a patient coming from Emerg, I need two IV poles and then I waste 10 minutes trying to look for it from other units. (RN 12, second interview, Site 2)
Nurses engaged in a variety of strategies to maximize their time, thereby improving their effectiveness in reaching for their goals for good care with their older adult patients and sustaining themselves as good nurses without sacrificing their wellbeing. A common strategy was to organize as many nursing activities at a time as possible. Planning activities so nurses could achieve many tasks with a patient maximized efficient use of time. A problem with this approach was that patients often received less nursing time because nurses confined their visits to concentrated activities. An example from a field note illustrates this point.

The RN explained that she was getting her supplies ready to enter the isolation room. She was going to wash him, give him medications, and re-site his intravenous (IV). Before gathering her supplies she checked to see if there was a washbasin in his room. She walked to another unit to obtain a basin. She gathered the rest of the items she would need to wash the patient and start an IV. When she tried to obtain his medications, she determined that they were not all on her medication cart, so she had to obtain an order for an analgesic and fax paperwork to pharmacy so that she was able to give the medication. It took her 15 minutes from her decision to wash her patient to gathering the equipment and medications. (Field note, Site 1, July 7)

Nurses justified infrequent visits to patients by indicating they were spending more quality time with patients when in the room doing several tasks. Whether nurses used building synergy to communicate openly with patients about their perceptions was not clear. Orchestrating care required nurses to spend their time as a precious resource. Time spent with patients or their families could provide opportunities to learn about their concerns and individualize care, which meant that the efficient use of time could be detrimental to nurses’ ability to build synergy, for example by sharing information. In this way, maximizing their time through efficiencies could constrain how nurses were building synergy,

Beyond individual patient care, nurses also tried to maximize their time by organizing their lines of action so they could attend to the greatest number of needs for their patient group.
and prioritize the most pressing needs. They could achieve that by working with another member of the nursing team. It was a common occurrence for nurses who worked side-by-side to discuss the assistance that they required from one another. Despite nurses’ plans to manage the care for their patients, there were frequent unexpected events where nurses would have to spend more time with a particular patient. By prioritizing a patient on the basis of acuity, they minimized their time with other heavy patients. This nurse explained how her goal of encouraging patients to be independent in their care could be derailed when another patient’s condition suddenly deteriorated.

Well I mean we try to get them, patients to do as much care for themselves as possible. Basically creating independence in patients if you can. Some days it doesn’t work out so well because we’ll have one patient that takes up so much time that you’re not able to take a patient for a walk. We have to juggle the acuity. (LPN 1, site 1)

Nurses juggled their time between enhancing the function of some of their patients and the acute needs of their other patients. Patient problems that received priority included difficulty with breathing, decreasing consciousness, low blood pressure, and infectious conditions. Categorizing patients as either acute or heavy influenced how nurses orchestrated care within their precious resource of time. Patients who nurses uncritically categorized as heavy were more likely to have their functional and comfort needs overlooked when nurses were creating time efficiencies to attend to areas they regarded as jeopardizing patient safety. Nurses’ use of these binary terms (acute and heavy) constrained their abilities to discern more nuanced assessments and constrained how they were orchestrating care.

Nurses also maximized their time by missing their breaks, coming early, staying late, or “cutting corners”. Missing breaks and staying longer than required for a shift had the potential to
undermine nurses’ wellbeing and jeopardize their goal of being good nurses. Cutting corners included missing steps in a procedure or rushing through a task to save time. Creating time efficiencies by cutting corners risked something essential being missed and errors being made. One nurse explained why cutting corners was to be avoided: “I don’t like the shortcuts. It ends up you’re doing more work. Cause you have to go back. Your patient is unhappy” (LPN 3, Site 2).

Cutting corners might get nurses’ tasks accomplished, but not attending to patients’ wishes for their care (such as preferring to receive their pills one at a time in a particular order) undermined individualized care and resulted in more difficult communication with unhappy patients. Similarly, the common practice of using incontinence products on all older adult patients could be viewed as a timesaver by nurses because they avoided searches for urinals and bedpans. In other instances, it was a means of allowing the acute needs of patients to supersede nurses’ efforts to promote function in the form of continence. Doing the physical care for older adults, which was faster than encouraging them to do it independently, undermined nurses’ goal of enhancing function in orchestrating care. These time-saving practices interfered with older adults’ capacity to be discharged—an institutional goal—and could indirectly influence the risks of overcapacity on the units.

6.3.2.2 Sharing experiences

Through sharing their experiences, nurses supported and learned from one another about how to orchestrate care to provide good care while still sustaining themselves as good nurses. Their efforts to foster relationships and to act as team players developed through building synergy, and influenced how they were learning about older adult care on the job. Most of the nurses did not have the benefit of any formal education about older adult care (only four of the
participants had had any formal education about older adult care). Thus, nurses minimized strain by learning about the complexity of the presentation and care of acute illness in older adults by having other nurses share their perspectives and experiences. As nurses questioned and described the situations they encountered and how they arrived at a course of action, they were, in effect, teaching each other about what constituted acceptable lines of action for the majority of older adult patients in a variety of contexts. This sharing of experiences served as the basis for nurses’ learning about how to manage older adult care.

The importance of sharing experiences was particularly evident in relation to crisis situations, when many nurses emphasized the importance of acting as a team player. Working together in crisis situations both built synergy and made knowledge and skills available so they could support and guide each other through these most difficult patient care situations. It was often during crisis situations that nurses reported their most significant learning about older adult care and about working together.

During my observations, I witnessed what happened when a patient was suddenly unresponsive, and saw how nurses came together to support each other in what became a shared experience. The clinical leader supported the nurses by taking the lead in reorganizing the patient load. In a subsequent interview, the nurse who was responsible for the unresponsive patient identified how this situation had taught her much about older adult care and about how to skillfully engage the nursing team. This example also highlights how the work that nurses were doing in navigating relationships as they were building synergy, was foundational to how they were able to work together in a crisis. Unfortunately, it also illustrates the tendency for nurses to rely almost exclusively on each other for support. Although the approach the nurses took to
orchestrating care relied on significant support from allies, it also resulted in drawing on other healthcare professionals for support only in very specific and time-limited ways.

Nurses relieved predominantly on other nurses who understood the context in which they were working, both for patient care advice and to alleviate the emotional pressures they experienced. One nurse succinctly explained: “When you have a nurse on your side it eases your stress” (LPN2, Site 1). Sharing practice challenges with allies was a helpful process that aided nurses in managing feelings arising from what they regarded as failing to provide good care. Turning to other nurses for support helped them interpret events so they could preserve images of themselves as good nurses. Nurses who shared their feelings and struggles received affirmation of their challenges and their desire to do better. One nurse explained: “It was a traumatic event and you want to share. You want to express your feeling on that to vent, fine. I’m all for that. It’s so important. Peace of mind is important for everybody” (RN 11, Site 2).

During participant observation, I observed nurses listening intently and expressing validation when other nurses were sharing their negative experiences. In such conversations, nurses were relying on each other to reinterpret the event and provide reassurance that they were all doing the best they could, given the circumstances. Unfortunately, sharing negative experiences reminded them that they were frequently in situations where they were unable to provide good care. It also permitted them to understand the situation differently, so that rather than addressing the implications of failing to achieve their goals, they could point, with support of others, to the healthcare system as the root cause of their failure to provide good care. Preserving their image of themselves as good nurses who were caught in “impossible” situations prevented them from taking responsibility, confronting the challenges associated with the healthcare system, and from accessing support from other sources.
6.3.2.3 Framing the work

Nurses who were trying to orchestrate care and frequently acknowledging that their goals for their patients were not met, reconceptualized or reframed their work to minimize the strain they experienced while orchestrating care. Reframing their work enabled nurses to support their images of themselves as good nurses. They described practices that undermined their espoused goals of good care and that were unsupported by evidence, but they reframed their actions as unavoidable and necessary given their challenging situations and limited resources. Because they knew these practices carried negative implications, they had to find a way to symbolize what they were doing that allowed them to continue their actions while still viewing themselves as good nurses. This was evident in how nurses renamed objects and practices to assign a positive valence to objects and actions that were counterproductive to their espoused goals.

A prominent example is how nurses reframed their routines of restraining older adults. While they acknowledged that restraining people (either through physical or chemical means) was not in keeping with hospital policy, was inconsistent with their goals of promoting function, and was detrimental to patients’ autonomy and wellbeing—thereby violating their goals of individualizing care and providing comfort—nurses reframed their actions as necessary for maintaining a calm environment that promoted the safety of all patients, which they held up as their primary goal. The resymbolizing of actions helped nurses absolve themselves of responsibility for undesirable practices.

Sedating patients through chemical restraints was viewed as promoting a calm environment. Nurses exhibited wide variation in the use of chemical restraints. Some nurses explained that: “I tend to be cautious about sedation. If they are really restless and awake I will sedate otherwise not” (RN1, Site 1). Other nurses reported using chemical restraints proactively
to prevent patients from demonstrating behaviours that could disrupt the ambiance of the units, such as calling out, trying to mobilize without assistance, or physically resisting nurses’ actions.

Nurses had autonomy in choosing how to use chemical restraints because the doctors’ orders frequently provided for a range of dosage to be used as needed; they learned how to manage these situations by sharing their experiences with each other. For example, one nurse explained how she promoted use of chemical restraints with other nurses in an effort to ensure that the tone of the unit remained calm: “I’ll just step right up to them and say I had this patient last night and Seroquel® worked really well, it usually takes the edge off” (RN 11, Site 2). By framing chemical restraints as a positive intervention to settle patients, nurses could minimize their responsibility for exposing patients to more drugs and resulting medication interactions, and thus sustain their views of themselves as good nurses. Symbolizing undesirable practices in positive ways contributed to their narrative that the healthcare system was the problem, and they were orchestrating care to the best of their abilities within this problematic system.

Similar to how nurses symbolized chemical restraints as sedation, they symbolized physical restraints as a necessary strategy to promote their goal of keeping patients safe to sustain their image as good nurses. I witnessed physical restraints during almost every participant observation, and was told by one nurse that this was reflective of their actual use, especially on night shifts: “[At night], we have them lined up in the hallway, three or four [geriatric] chairs” (RN 7, Site 1). Nurses used geriatric chairs as a form of physical restraint and brought patients to the central nursing desk in an effort to promote safety. Keeping these patients at the desk enabled nurses to use surveillance and provided justification to intervene with chemical restraints if the physical restraints were not achieving the goal, which was to minimize disruption of the unit
overall and prevent patients from ambulating on their own. The geriatric chair was so commonly associated with safety that it was called a “safety restraint”. One of the participants explained:

The geri-chair with the table. It is a restraint or it’s more of a passive restraint. It’s kind of like a safety restraint. You can’t have this perfect no restraint policy. It’s not practical. It’s not safe. You’ve got a patient who is very, very sick, they’ve got tubes coming in and they’re climbing out of bed. It comes down to safety. (PCA 3, Site 1)

By reframing physical restraint as a safety restraint, nurses were aligning their care with the institutional goals of keeping patients safe (albeit a very narrow definition of safety). Although restraints violated other goals of good care, for example, promoting function or providing individualized care, and broader definitions of safety, such as prevention of damage from immobility, nurses presented restraints as necessary practice in orchestrating care.

One nurse articulately explained how thinking shifts when geriatric chairs come to be framed as positive interventions.

That’s one of those grey areas. Technically a geriatric chair is a restraint if you use it that way. Sometimes it’s a comfortable chair that gives you a position change and the elder person actually is more comfortable. Once you put the tray on. If they’re okay with the tray it is not necessarily a restraint. At night [nurses] bring them out where you can see them and it’s a way to see them so that they’re safe and maybe they’ll even settle and fall asleep. (Bystander 1, Site 1)

Viewing the geriatric chair as a grey area of restraint use allowed it to be reframed as a positive intervention to keep patients and the rest of the unit safe.

Nurses described their common understanding that monitoring a confused patient using one-to-one nursing surveillance was a better option than restraints. “It’s better not to [restrain] and try to think of other options. I mean more staffing, like one-to-one” (Bystander 1, Site 1). A one-to-one nurse could offer reassurance, perhaps take the older person for a walk, while
ensuring that the potential disruption to the unit was minimized. One-to-one nursing would support goals of individualized care and enhancing function—two goals of orchestrating care.

Unfortunately, nurses had to present a strong rationale for obtaining the extra staff to provide one-to-one surveillance, and even if their managers approved their requests there might not be staff available for this work. One nurse explained what I heard from most of the participants: “You can’t get one-to-one for that patient so that’s when they put the restraints on and restrain that patient. There’s no other choice than to do that” (RN 11, Site 2). It comforted nurses to believe that they had no choice but to restrain their older patients using the rationale that keeping their patients safe at all costs was their primary goal and the system had failed their efforts to do otherwise.

Nurses’ perceptions that resources were tight and they had to make do with what they had, enabled them to sustain their images of themselves as good nurses. Unfortunately, the ways in which nurses were reframing their work contributed to their difficulties in meeting their other goals and getting the recognition they desired for their work. Symbolizing the healthcare system as causing their predicament inhibited nurses from articulating their concerns, taking responsibility for their practice, looking to other healthcare professionals for support, and examining alternative ways of practicing in their nursing teams that were supported by evidence. Thus, some efforts to minimize strain interfered with nurses’ efforts to build synergy and orchestrate care effectively.

6.3.2.4 Summary

In summary, nurses engaged in the continuous process of minimizing strain to create supportive networks for orchestrating care that they framed as good and that enabled them to
sustain their images of themselves as good nurses. Nurses used each other’s knowledge of hospital systems and other units to find resources because of the constant struggle in accessing what they needed for their patients. Although they employed a variety of strategies as a means to maximize their time, these strategies frequently undermined nurses’ opportunities to spend time assessing and getting to know their patients as part of building synergy. The relationships that nurses developed in building synergy aided them in supporting and learning from one another by sharing their experiences, but it also served to reinforce their view that they only had each other to rely on and led them to practice in ways that did not always align with their goals. Nurses symbolized the healthcare system as the cause of their problem and they saw their only true allies in other nurses. This view limited their opportunities to build synergy with other healthcare professionals, and to explore different ways of practicing within the nursing team. Moreover, nurses reframed negative objects and practices in positive ways by justifying their activities through the primary yet narrow goal of keeping patients safe. Sustaining the perception that nurses were good nurses operating in a “bad” system perpetuated these undesirable practices.

6.4 Chapter Summary
In this chapter I have explained how nurses were managing their problem of providing good care for their hospitalized older adults, while still sustaining themselves as good nurses through the process of orchestrating care. Orchestrating care explains how nurses were continuously trying to manage their work environments by understanding the status of the patients on their unit, their levels of staffing and the characteristics of their unit, mobilizing the assistance of others, and stretching available resources to resolve their problems. Nurses symbolized good care in terms of keeping patients safe, providing individualized care, enhancing function, and promoting comfort care at the end of life. They symbolized sustaining themselves
as good nurses as meeting obligations and competencies and being able to reflect on their practice and to feel they did the best they could for their patients in difficult circumstances. Nurses described feeling overwhelmed by their professional responsibilities and expectations of patients, families, other healthcare professionals, and their managers. Moreover, they tended to regard other nurses as trusted allies in the context of the complexity of caring for older adults in problematic hospital systems where they felt ignored or misunderstood.

Nurses used the continuous process of building synergy to orchestrate care by leveraging assistance from others to resolve their problem. Building synergy within a nursing team comprising different providers with varying levels of education and experience, combined with the need to prioritize life and death patient concerns, led nurses to symbolize their patients as either acute or heavy. Patients symbolized as heavy received less attention, potentially leading to detrimental consequences in meeting the goals (e.g. promoting function) espoused by nurses for orchestrating care. Moreover, using the symbol of heavy did not aid nurses in making a case for more staff because older adult care was presumed to be always heavy; it was nothing special or unusual. The nursing team symbolized helping as key to being a good team member; however, RNs, and particularly experienced RNs, often had the most extensive patient care responsibilities. This inequity, combined with nurses’ perceptions that their only allies were their nurse co-workers, inhibited nurses from seeking support from other healthcare professionals.

Minimizing strain was another continuous process that contributed to orchestrating care by explaining how nurses were stretching their resources and relying on one another to reduce their distress about failing to provide good care, while reconceptualizing their practice in ways that allowed them to sustain their self-image as good nurses. Although nurses were creative in maximizing their resources, the chronic lack of supplies and equipment in combination with
hierarchical relationships with other healthcare providers that placed nurses at the bottom of the ladder, contributed to nurses attributing all of the difficulties they had with meeting their goals for orchestrating care to the healthcare system and their view of other healthcare professionals as possible adversaries. In order to continue to practice and sustain their self-image as good nurses, nurses reframed undesirable practices in positive ways; they viewed these practices as something they had to do to orchestrate care in challenging circumstances. Unfortunately, nurses’ perceptions that only other nurses were allies prevented them from taking responsibility for poor practices, articulating their challenges, and from developing relationships with other healthcare professionals and patients and families that were directed to changing the system. Viewing undesirable practices as inevitable within the healthcare system enabled nurses to abdicate their responsibility to contribute to a solution.
CHAPTER SEVEN: DISCUSSION

7.1 Introduction

In this study, I used grounded theory guided by the theoretical framework of symbolic interactionism (SI) to explore nursing practice with hospitalized older adults. Chapter Five set the stage by describing the settings and participants in this study. Chapter Six provided an explanation of nursing practice with hospitalized older adults through the theory of orchestrating care. This theory has answered the research questions posed in chapter three. They are: how do nurses enact nursing practice with hospitalized older adults; what facilitates nursing practice with hospitalized older adults’ and what constrains nursing practice with hospitalized older adults? This final chapter discusses how the theory has answered the research questions and situates the theory in light of the existing literature. It begins with an overview of the theory, followed by a discussion of how these findings contribute to current understanding. The chapter concludes with a discussion of limitations, and the implications for nursing practice and nursing leadership, education, research, and policy.

7.2 Overview of Theory: Orchestrating Care

In the preceding chapter I have explained how, through the process of orchestrating care, nurses were managing their problem of providing good care for their hospitalized older adults, while still sustaining their views of themselves as good nurses. Nurses articulated good care in terms of four key goals: keeping patients safe, providing individualized care, enhancing function, and promoting comfort care at the end of life. They symbolized sustaining themselves as a good nurse as being able to reflect on their practice and feel they did the best they could in meeting their professional obligations in difficult circumstances.
Orchestrating care comprised two processes. These processes answered the research questions by explaining how nurses were practicing with older adults and by illuminating the factors that facilitated nursing practice and the factors that constrained nursing practice with hospitalized older adults. Through building synergy, the nurses were seeking to increase their capacity to provide what they believed to be good care in an environment that they saw as challenging, and where they felt as if they were working with few allies. I have used the symbolism of being under siege to explain how nurses were feeling pressure from the multiple and sometimes conflicting expectations from their manager, other healthcare professionals, families and patients, and especially, their own professional obligations and responsibilities, and attributing the cause of the pressure to the healthcare system. Building synergy in such a context meant that to successfully orchestrate care, the nurses also had to attend to minimizing strain in an effort to ease these pressures.

Building synergy is explained by three properties. Doing reconnaissance explains how nurses were constantly surveying and evaluating their patients’ health status and their available resources. Passing information explains how nurses were serving as a central conduit of what they viewed as significant patient-related information, primarily among themselves, but also to and from patients and families, and between members of the healthcare team. Navigating relationships explains how nurses were negotiating the varied expectations about working within a team. Nursing practice with hospitalized older adults was facilitated by nurses working together to do reconnaissance and pass information; it was constrained by unclear understandings of how to best work together within the nursing team and multidisciplinary teams.

Minimizing strain is also explained by three properties. Maximizing resources explains how nurses extended their time and physical resources. Sharing experiences explains they how
supported and guided one another in managing difficult and unsuccessful situations. Reframing the work explains how nurses reinterpreted care practices that were not in keeping with some of their goals to maintain their image of themselves as good nurses. Nursing practice was facilitated through nurses drawing on one another to find resources and support one another; unfortunately, their practice was constrained through the transmission of negative practices and the reframing of these practices as helpful strategies in the care of hospitalized older adults.

To some degree, building synergy and minimizing strain served to reinforce each other by improving nurses’ efforts to successfully orchestrate care. The relationship between building synergy and minimizing strain was complex as a result of how nurses symbolized their practice in the context of the challenging structural issues that were part of their day-to-day reality. Much of the work that nurses were doing to minimize strain and sustain their view of themselves as good nurses rested on their belief that the challenges they faced in orchestrating care resulted from system-level inadequacies that were not going to change. In short, they felt inadequate care was not their fault.

While the evidence from this study clearly identifies that system issues were very real and served to constrain nursing practice, nurses’ perceptions that the source of their problems lay outside their practice and that only other nurses could support them in orchestrating care prevented them from effectively building synergy and minimizing strain. In these ways, nurses’ ability to successfully orchestrate care was undermined, not only because they found themselves in a work environment with serious structural constraints, but also because how they made meaning of their work served to constrain their own agency.
7.3 **Orchestrating Care**

The theory of orchestrating care offers an explanation of the strategies nurses are using to provide what they define as good care, how they defend their strategies, and the implications to both their older adult patients and their practice as a result of how they are defending their strategies. The plethora of research identifying challenges associated with caring for hospitalized patients supports my presentation of nurses as feeling besieged due to the pressures they feel within their work environments. Nurses find it challenging to provide basic safe care within strained hospital environments (Goveia, 2009; Higgins et al., 2007; IOM, 2004; Peek et al., 2007; Rodney & Varcoe, 2012), which often results in their moral distress (Austin, 2007; Pavlish et al., 2011; Rodney & Varcoe, 2012). Many of the issues are at a systems level (Boltz et al., 2008; Cheek & Gibson, 2003; Dahlke & Phinney, 2008; Kim et al., 2009; McKenzie et al., 2011), leading to impoverished care environments, especially in the area of older adult care (Sellman, 2009; Wakefield & Holman, 2007). My theory contributes to this large body of literature by extending current understanding of how nurses are caring for hospitalized older adults. For example, my theory provides insights into how nurses are responding to system challenges that constrain their practice and some of the mechanisms by which nurses handle moral distress.

In the discussion that follows, I will draw attention to four particular issues that stood out as important aspects of this theory. These issues highlight the complexity of nursing practice with hospital older adults within structural constraints, where practices that nurses employ to facilitate what they define as good care serves to both facilitate and constrain their practice. The first two are how nurses were building synergy through their symbolic use of language (naming patients as acute or heavy), and through their joint lines of action within nursing and
multidisciplinary teams. The remaining two issues relate to how nurses were minimizing strain through their meaning-making around the apparent gaps between available resources and patient needs (leading to the prioritizing of safety as a primary goal of care), and by learning the processes of orchestrating care through their interactions with each other in part through how they were reframing practices that contributed to their moral distress.

7.3.1 Building Synergy

Nurses were orchestrating care through the two continuous processes of building synergy and minimizing strain. These processes explain how nurses were caring for hospitalized older adults. Building synergy explained how nurses were gathering and sharing information, and working with others to increase their capacity to resolve their problem of providing good care while still sustaining themselves as a good nurse. Quickly determining the status of their patients, their available resources and the other members of the nursing team were important elements in building synergy. To achieve this nurses relied on a type of shorthand using the symbols “acute” and “heavy” to describe to each other the status of their patients and the resources required to care for them. This language facilitated nurses in identifying that certain (heavy) patients required more physical care; however it did not differentiate between patients who required more physical care as a result of an acute illness and those who required ongoing physical care due to a chronic condition. As a result, nurses’ use of the symbol heavy constrained their practice.

This language of acute and heavy is common in nursing practice. Other scholars have identified that similar discourse is especially associated with older adult care and contributes to how resources are allocated (Kjorven et al., 2011; Neville, 2005). Using a poststructural/postmodern critical discourse analytical framework to examine the language nurses use and how that shapes their care with older adults, Kjorven and colleagues (2011)
suggested nurses’ language serves to normalize delirium in older adults and relegate their acute needs as illegitimate. Nurses in my study not only indicated that they often put the needs of the patients they defined as heavy after the patients they defined as more acute, but they also suggested that the heavy patients did not get the care they required because less educated nursing personnel had been assigned to attend to the mobility and hygiene needs. Functional changes such as these can be a symptom of ‘acute’ issues in older adults (Barakzai & Fraser, 2008; Fedarko, 2011). Thus nurses’ use of the term heavy did not capture the complexity of how acute illnesses can present as functional needs in older adult patients.

This practice of assigning patients nurses described as heavy to less educated members of the nursing team contributed to less available time for nurses to assess (an important element of building synergy) and respond appropriately to the signs of acute illness in these patients that had been labelled as heavy. Focusing on prioritizing acute patient care needs was also at odds with nurses’ goals of providing comfort care to older adults at the end of their life, an issue that has been discussed at length by Stajduhar (2011). It would seem that use of the binary terms (acute versus heavy) constrained nurses’ abilities to assess and describe the nuances of many of their complex older adult patients who were acutely ill and yet this acuity was manifest through functional needs. In these ways, describing patients as heavy could constrain nurses’ abilities to be doing reconnaissance.

Nurses’ allocated their scarce resources based on how they understood the term heavy; enhancing function was not as important as the life and death issues they associated with the term acute. The complexity of how nurses were symbolizing certain older adults as heavy is situated within a broader social perception of older adults that has been debated within the literature. Many scholars have identified a social perception that older adults are using too many
of the scarce healthcare resources (Carriere, 2000; Dahlke & Phinney, 2008; Evans et al., 2001; Evans, 2007; Garrett & Martini, 2007; Gee, 2000; Hebert, 2003; Martin-Matthews, 2000). Even though scholars have demonstrated that the increased costs in healthcare are associated with technology rather than the age of the healthcare consumer (Evans, 2007; Health Council of Canada, 2008), these negative perceptions persist. These prevailing views contribute to the social environment in which nurses experience lack of access to resources and information, in part as a result of their limited access to other healthcare team members.

The language of acute and heavy that nurses were using to help them prioritize and make quick decisions was situated within broader social views about older adults. Nurses in this study recognized that the symbol heavy, in particular, was widely associated with the nursing care of older adults. Scholars have identified how the language of heavy is common among nurses, and reflects the taken-for-granted view that older adult care is hard physical work and requires less thinking (Brown et al., 2008; Cheek & Gibson, 2003; Deschodt et al., 2010; Flood & Clark, 2009; Ironside et al., 2010; Kjorven et al., 2011; Xiao et al., 2008). This helps to explain why nurses’ use of the symbol heavy undermined their ability to articulate their patients’ needs to their managers in a way that could result in more staff. Since older adult care was uncritically viewed as not requiring complex thinking, nurses’ use of the symbol heavy to explain the complexity of their older adult patients with both chronic and acute needs did not get their important message across to their managers. Furthermore, using the symbol heavy served to reinforce the notion that their practice was hard, which reinforced their feelings of being under siege, and further limited their efforts in articulating their challenges to those outside the “inner” nursing circle. These findings highlight how the theory of orchestrating care explains not only
what nurses do, but more importantly how their practices are shaped by the language they use to construct meaning around understanding the needs of their patients.

Another important element of building synergy was how nurses communicated with and worked with other members of the healthcare team. Working in teams, whether it was nursing teams on the unit or multidisciplinary healthcare teams, was presented by nurses as essential to orchestrating care. Participants explained how well functioning teams facilitated care of older adults and care could easily be constrained if teams were not working effectively. This study offers novel insights into how roles within the nursing team and nurses’ perceptions about their value within the multidisciplinary healthcare team influenced how they orchestrated care. Being a part of a nursing team comprising a variety of roles and education and experience levels was challenging, in part because nurses symbolized helping and reciprocity as key to being a good team member, and team members could not always make equivalent contributions to patient care. Scholars have identified the impact of roles and experience in how nursing teams are constructed and in how individuals work together (Duffield, Roche, Diers, Catling-Paul, & Blay, 2010; Harris & McGillis Hall, 2012; Schmalenberg & Kramer, 2009); however, a clear idea about how best to construct nursing teams has not been articulated within the literature. The findings of this study highlight how recent restructuring of acute care nursing teams, and in particular the incorporation of practical nurses and unlicensed care staff, has altered the nature of working in nursing teams with registered nurses taking the brunt of responsibility to manage acutely ill patients in their patient loads.

The Canadian Nurses Association (CNA, 2012) has identified five guiding principles for staff-mix decisions that consider patients’ safety and quality of life for patients and staff alike. These guiding principles include ensuring that staff-mix decision-making is: responsive to
clients’ healthcare needs; guided by evidence; supported by the organizational structure and institutional systems; and includes nursing staff in the decision-making process. Evidence from my study suggests that neither patient nor staff quality of life were being considered in the composition of the nursing teams that had changed within the last five years to include full scope licensed practical nurses (LPNs)\textsuperscript{16} and patient care aides (PCAs). Moreover, the nurses in my study made it clear they were largely ignored in decision-making processes. These changes are reflective of changing nursing teams within hospitals throughout Canada (Harris & McGillis Hall, 2012). To better understand these changes, the CNA commissioned Harris and McGillis Hall (2012) to conduct a focused literature review on the patient, care provider, and organizational factors that influence staff-mix decision-making; these scholars identified a deficit in research examining use of full scope LPNs and care aides (PCAs) in hospital settings. In support of scholars’ claims about the lack of evidence about the effectiveness of how current nursing teams are organized, my study suggests members of nursing care teams did not have a consistent, clearly articulated understanding about how to best distribute the care of their older patients among themselves. This absence of clarity about how to best utilize the various roles contributed to nurses clinging to long-established ideals of reciprocity among team members that worked best when all team members had the same role. Looking for reciprocity is problematic in the current context, because many of the roles that RNs were occupying could not be repaid in kind due to variations in nursing care team members’ education levels and scopes of practice. Focusing on reciprocity constrains nursing team members from critically thinking about how they can work together in ways where helping one another is defined differently. While there are studies that are beginning to examine how new nurses with little experience are fitting into

\textsuperscript{16} Full scope refers to a process that has occurred in the last decade to shift some of the tasks previously assigned only to RNs to LPNs. For example, administering medications, managing intravenous lines, etc. This type of work shifting is occurring across the world (World Health Organization [WHO], 2008).
nursing teams (Boychuk Duchscher, 2008, 2009; Cline, Rosenberg, Kovner, & Brewer, 2011; Feng & Tsai, 2012; Housmand, O’Reilly, Robinson, & Wolff, 2012), my theory adds to our understanding about the work of acute care nursing teams that are characterized by variations in education and skill mix.

This study also offers insights into nurses’ perceptions of their lack of significance within the multidisciplinary team and how that influences their interaction with these team members as they are attempting to build synergy, and ultimately how they orchestrate care. Although research suggests that older adult care is improved when there is collaboration among healthcare disciplines (Arbaje et al., 2010; Benedict et al., 2006; Boult et al., 2009), a clear understanding about what types of multidisciplinary teams would be most effective or how to nurture relationships within healthcare teams (especially those who are working different hours than nurses) has not been established. It seems evident that collaboration is more likely to occur if all healthcare team members understand each others’ competencies and scopes of practice.

Scholars have identified that the schedules of other healthcare professionals influence nurses’ ability to communicate about their patients’ concerns and diminishes their ability to develop collaborative relationships with other disciplines (Smith, Lavoie-Tremblay, Richer, & Lanctot, 2010). The nurses in my study understood that they worked primarily with other members of the nursing team, and symbolized their relationships with other disciplines in terms of a healthcare hierarchy with nurses at the bottom. Their view of nurses occupying a position of less power than other professionals (and particularly so in their relationships with physicians) has been documented since Nightingale’s days, and it remains an undercurrent in nursing practice today (Cheek & Rudge, 1994; Keddy, Jones Gillis, Jacobs, Burton, & Rogers, 1986; Speedy, 2005, 2009). Nurses’ views of holding less power and being of less value than other healthcare
disciplines contributed to them seeing each other as their only allies. Ironically, this inward focus fostered a distrust of other disciplines and diminished nurses’ multidisciplinary collaboration, which in turn reduced their ability to effectively build synergy, and constrained their effectiveness with orchestrating care.

Nurses’ understanding of their place within the multidisciplinary team also affected how they communicated with other healthcare professionals. Scholars have identified the essential role that nurses play in ensuring the passing of information, coordinating, planning, and caring for older adults (Buljac-Samardzic, Dekker-van Doorn, Wijngaarden, & Wijk, 2010; Edwards & Donner, 2007; Kilpatric, 2012; O’Brien, Martin, Heyworth, & Meyer, 2009). Specifically, Edwards and Donner (2007) conducted an interpretive phenomenological study examining how information and knowledge is passed among nurses and other healthcare professionals. They identified that nurses made judgments about what others need to know or care about, and restricted their communication based on those judgments. My study has contributed to the literature by revealing that nurses do not communicate as much with other healthcare professionals as they do with each other, not only because there were limited opportunities for nurses to interact with other healthcare disciplines but also because nurses did not regard their contributions as being valued. Other healthcare disciplines frequently neither worked the same hours as nurses, nor did they work only on one unit, which together meant there were reduced opportunities for nurses to clearly understand the other healthcare professionals’ roles and the valuable information that nurses could be passing to them.

Lack of understanding about other healthcare professionals’ preferences for information could explain why nurses frequently communicated patient care needs to physicians in an indirect manner, by presenting details that nurses hoped would lead the physician to the same
conclusions that the nurse had already reached, rather than directly stating what the nurse believed was happening with the patient. This indirect way of communicating has been described as “pointing and building the case” (Edwards & Donner, 2007, p. 147). Using this communication style seemed to be a way nurses in my study negotiated what they perceived to be unequal power relations; Keddy and colleagues (1986) referred to nurses’ symbolization of physicians as a “boss.” In these ways, building synergy as a key subprocess of orchestrating care contributes to an understanding about the complexity of working in nursing and multidisciplinary teams. My study has added an explanation of the link between nurses’ perceptions of their place within multidisciplinary teams and turning their gaze inward to the nursing team for support, despite what are perceived as inequities within the roles of the nursing team. Thus it would seem that nurses’ negative perceptions of their value in the healthcare team served to constrain how they were able to orchestrate care.

7.3.2 Minimizing Strain

The other subprocess of orchestrating care is minimizing strain, which explains how nurses were stretching their resources, relying on one another for support and learning, and interpreting the meaning of their practices in ways that made it easier for them to position their care as good and to survive as good nurses. Relying on one another for accessing resources and support facilitated nurses’ practice with hospitalized older adults. Unfortunately, when nurses were sharing strategies on how to manage in challenging circumstances, they were teaching one another negative practices and framing them as positive and necessary, thus constraining their ability to provide the care they defined as good. Nurses’ chronic struggle in relation to an inadequate healthcare system, especially as it pertains to older adult care, has been well established in the literature and was obvious also in this study. However, what stood out was the
extent to which minimizing strain was related to how nurses’ made meaning of their work environment, which influenced how they organized their care and prioritized their goals of care to focus on a narrow view of safety above all else.

This study clearly identifies how nurses viewed the healthcare resources in these acute care environments as inadequate to support what they defined as good nursing care of older adults. These inadequacies were reflected in the chronic presence of overcapacity patients (being forced to provide care for more patients than their funding and staffing allowed), the organization of resources around a Monday to Friday schedule (despite the need for many of these resources 24 hours a day, seven days a week), and the constant lack of basic equipment and supplies (forcing them to search for items like food, bedpans, and wash basins). Rodney and Varcoe (2012) have written about how scarcity is reflected through nurses’ constant struggle to access healthcare resources. They explain how nurses’ perceptions about the scarcity of resources contribute to them organizing their work routines to achieve greater efficiency and rationing their time to provide more care to the patients they perceive as most acute. My findings about nurses’ efforts to increase efficiency and privilege care for acute patients fit with Rodney and Varcoe’s claims, specifically how nurses’ perceptions about the scarcity of resources contribute to them organizing their work routines to achieve greater efficiency and rationing their time to provide more care to the patients they perceived as most acute. My theory of orchestrating care extends their understanding by explaining how nurses were constructing meaning about how to prioritize their patients’ acute needs by maximizing their access to limited resources on the one hand, and foregrounding safety—within a very narrow definition—as the primary goal of care on the other hand. Therefore, not only were the inadequate resources constraining nurses practice, but how the nurses themselves were responding was inadvertently
further constraining their practice. Utilizing negative practices (such as restraint) to keep patients safe were not only detrimental to their older patients, but also inadvertently increased nurses’ workloads (e.g. patients could become deconditioned from being restrained and then require more nursing care).

Orchestrating care, particularly through the process of minimizing strain, provides explanations about how nurses were managing care by negotiating the perceived gap between institutional resources and the needs of older adult patients. These gaps have been described as the “in-between” place, where nurses mediate their practice amid perceptions about older adults, hospital systems, and physicians (Bishop & Scudder, 1990). Nurses were minimizing strain associated with these gaps by stretching resources and simplifying how they interpreted the needs of older adults. While they referred to other goals—individualizing care, providing comfort care, and so forth—in practice they focused on what they saw as essential: keeping patients safe. Provis and Stack (2004) argued that nurses’ relationships with their older patients provide them with an awareness of the gaps between institutional resources and the needs of individual patients. My study refutes their claims to the extent that nurses in my study did not focus on needs of individual patients. Rather, they simplified how they thought about the needs of patients by focusing their goals of care on safety in an effort to minimize the strain of trying to find resources while meeting the expectations of their profession, managers, patients, and families. Nurses’ focus on their goal of keeping patients safe favoured a particular understanding of safety that emphasized keeping patients from falling or pulling out the tubes needed for medical treatment. Although nurses in my study felt they had limited means to control their

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17 I refer to Bishop and Scudder’s (1990) work of explicating how nurses are mediating their nursing practice between the traditional authority of physicians, older adults’ rights, and pressures from management to efficiently move patients through the system.
access to resources, they were able to control how they prioritized their care with the patients on their units in ways that minimized their strain when orchestrating care.

The fact that safety emerged as an overriding goal may not be surprising, given that nurses were making meaning of their practice in a socially constructed hospital environment that identified “safety first.” Nurses also identified professional obligations to protect their patients from harm. It has been argued that acute care work environments and staffing levels are frequently inadequate to ensure patient and worker safety (Butler et al., 2011; IOM, 2004). Issues around the relationship between nursing care and patient safety are receiving extensive attention in the research literature (e.g. Aiken et al., 2011, 2012; Debourgh, 2012; Dickson & Flynn, 2012; Dresser, 2012; Jeffs, Affonso, & MacMillan, 2008; You et al., 2013), with scholars identifying how nurses caring for older adults are increasingly framing their practice in terms of risk management and “safety work” (Ludwick, Meehan, Zeller, & O’Toole, 2008; Schofield, Tolson, & Fleming, 2012). All this supports my explanation of how nurses in this study were led to construct keeping patients safe in such narrow ways as a means of defining a manageable practice of safety.

The process of minimizing strain also offered insights into how nurses were learning about older adult care though their social interactions that occurred while they were orchestrating care in impoverished work environments. Using the theoretical framework of symbolic interactionism in conducting this study has been pivotal in illuminating the social construction of nursing practice. Nurses were constantly making meaning of their work circumstances, creating joint lines of action, and redefining their lines of action through their interactions with one another within their social environment and, in the process, were learning from one another. Bandura (1971) offers an important theory that explains the social nature of learning. His theory
explains that when people are confronted with novel experiences they learn how to respond to these experiences by observing and cognitively processing how others in their social environment are responding to determine if they will respond in the same ways. In my study, novice nurses (who had more formal education about older adult care than the more seasoned nurses) were learning from seasoned nurses the efficient ways to care for older adults in challenging contexts by observing these experienced nurses in action and seeking their support and guidance. Findings revealed that nurses did not believe they had the time or resources to follow many of the “best practice” guidelines that were promoted by their workplace; therefore it was the practices they learned from one another that were more commonly utilized.

Estabrooks (2003, 2008, 2009) and McWilliam et al., (2008) have also identified nurses are more likely to learn from their co-workers, than from the “evidence-based” practices that are identified in the literature. Thorne (2009) cautions nurses to find a middle ground between privileging either “clinical wisdom” or evidence-based practice. Both of these ways of knowledge can offer insights about how to respond to a practice challenge, and both also need to be carefully considered to determine if they offer the best solution to a particular practice problem.

Nurses in this study explained that they learned from more experienced nurses and their knowledge about what to do in particular circumstances developed over time. Nurse theorists have long argued that nursing practice evolves “from novice to expert” through decisions that are embedded in nurses’ day-to day practice (Benner, 1984), and that personal ways of knowing are grounded in experience (Carper, 1978). There are also theoretical similarities between how the nurses in my study were learning from one another and Liaschenko and Fisher’s (1999) discussion of the social construction of knowledge and how nurses’ apply knowledge. These
scholars theorized that nursing knowledge includes case (general knowledge of pathophysiology, pharmacology, and therapeutic protocols), patient (knowledge of healthcare systems, and patients’ responses to treatment), and person (knowledge of individual care recipients) knowledge (Liaschenko & Fisher, 1999). Similarly, in my theory, nurses used their social knowledge of their unit, nursing team capacity, and hospital systems to decide what were the possible strategies to keep their patients safe, and they passed this social knowledge to one another as they were orchestrating care. My theory extends the explanation offered by these aforementioned theories by explaining how nurses are learning from one another in highly contextual and often extremely challenging circumstances. These circumstances contribute to their perception that the problematic healthcare system is not going to improve, which serves to constrain their willingness to learn responses to their practice challenges that are not simply focused on dealing with emergency situations. Furthermore, their learning is influenced by their perceptions of how they fit within the multidisciplinary team, which limits healthcare personnel from whom they are willing to learn. In these ways, while minimizing strain aided nurses in learning practical ways to manage challenging care situations, it also constrained their ability to situate their learning in evidence-based practice to support their efforts to be effective at orchestrating care.

Managing the care of older adults in challenging care situations is situated within nurses’ socially defined role of caring for vulnerable people, a symbol that is deeply embedded in our society as evidenced by the high trust the public bestows on nurses (College of Registered Nurses of British Columbia [CRNBC], 2012). There is a body of literature that explains the emotional work necessary for helping professionals so that they can continue to occupy their socially defined roles (Bone, 2002; Froggatt, 1998; Henderson, 2001; Hochschild, 1979, 2003,
2005). Similar to the flight attendants in Hoschschild’s studies, based on my study I would argue that nurses have been socialized into feeling responsible for the safety of vulnerable patients, beginning in their nursing education, promoted by professional nursing associations, and reinforced by public institutions such as hospitals.

Nurses in my study felt the weight of the responsibility of the high trust bestowed upon them by the public, as well as the pressures of caring for vulnerable older adults in hospital environments where they felt inadequately supported and where they believed they were not always meeting their ideals of providing good care. To minimize the strain of these responsibilities, nurses focused on a narrow definition of safety as their primary goal, and looked to one another for support and guidance about how to best orchestrate care toward this end. In this way, nurses were learning strategies from one another that were not supported as best practices within the nursing literature. Moreover, privileging nursing knowledge based on experience as the answer to practice challenges perpetuated the idea that time spent taking care of older adults equalled knowledge about how best to take care of them (Brown, Nolan, & Davies, 2008; Deschotd et al., 2010; Flood & Clark, 2009; Ironside et al., 2010; Xio et al., 2008) and served to reinforce social ideas that older adult care is simple and basic and does not require advanced nursing knowledge (Ironside et al., 2010; Xio et al., 2008).

7.5 Limitations

Although the theory of orchestrating care has offered many insights into nursing practice with hospitalized older adults, the study has limitations. This theory presents a nursing perspective. Although novice nurses were part of the sample, their unique perspective was not explored in-depth. Patients and other members of the healthcare team also have important perspectives about the care of hospitalized older adults that are not represented in the findings.
Furthermore, this is a study with a single investigator and is thus limited by time and perspective. Although the questions and insights of committee members have helped to enhance the investigator’s viewpoint, the questions arising from this theory have pointed to the need for more study to extend the understanding about nursing practice with hospitalized older adults.

7.6 Implications and Suggestions

Notwithstanding the limitations, there are potential implications for nurses, administrators, educators, researchers, and policymakers that are evident from the theory of orchestrating care. The theory of orchestrating care has foregrounded the importance of nurses’ position at older adults’ bedsides 24 hours a day, 7 days a week. Although the findings show that nurses are not leveraging this role to its full potential, they do suggest that there are many improvements to care that could be actualized by paying close attention to nurses’ unique perspectives about the complex ways in which institutional systems and patient care needs intersect. Nurses in this study indicated they did not believe their perspectives were valued and as a result they did not articulate their concerns. Similarly, scholars have identified that workplace environments are effectively silencing nurses by not validating their concerns (Newton et al., 2012). It is vital that nurses’ unique perspectives are shared with managers, educators, researchers, and policymakers. Nurses need to be encouraged to become involved in committees within their workplaces, as these can provide opportunities to articulate their practice concerns. Nurses’ involvement in their professional organizations to identify practice challenges is a further way to bring voice to their day-to-day struggles. The Canadian Nurses Associations’ (CNA, 2012) decision-making frameworks could be used to support them in articulating the kinds of practice challenges identified in my study, and in advocating for processes within their institution that would include nursing voices for solving ongoing practice challenges.
Nursing leadership can play an important role in aiding nurses to articulate their roles within nursing and interdisciplinary teams in order to enhance how these teams work together in advancing care of hospitalized older adults. Providing forums as a safe place for nurses to articulate their practice challenges and to be critically reflexive about their practice would be one way to begin the dialogue. It is important that leaders and administrators use these forums to listen to the challenges nurses articulate and thoughtfully work with nurses in addressing the many layers of complexity among nursing and interdisciplinary teams, as well as healthcare systems. A useful starting place for leadership to explore in forums would be how nurses are building synergy through the language they use in assessing their patients (e.g., acute and heavy), and their perceptions about working with others (e.g., being positioned at the bottom of a healthcare hierarchy). Leaders who work with nurses in unpacking the complexity that nurses intend when they use the word heavy will facilitate clearer communication patterns among nurses and team members. Discussions about the roles of all members of the healthcare team and the pivotal role nurses play in relation to communication and care of older adults would be a first step in facilitating more effective interdisciplinary healthcare teams.

Leaders and administrators need to go beyond acknowledging that the healthcare system has problems, to support nurses in orchestrating care with hospitalized older adults in simple yet concrete ways such as providing patient care units with food, water, and basic equipment. Nursing leaders and administrators who pay attention and seek to minimize these and other gaps that nurses are negotiating within the healthcare system could minimize the strain nurses experience on a day-to-day basis as they are learning from one another about how to best orchestrate care. Certainly, there is much evidence to suggest that the healthcare system offers many challenges to nurses practicing with hospitalized older adults (e.g., Aiken et al., 2008,
This study illuminated how systems are organized around a Monday to Friday schedule even when patients are admitted to hospitals seven days and seven nights a week. Nurses spent time looking for supplies especially during off hours and weekends because of the way these systems were organized. It is logical to consider that if the basic tools and structures necessary for nursing practice were easily available, nurses could spend time providing care to their patients, rather than looking for supplies, or waiting until Monday to seek support from another healthcare provider. Leaders and administrators who work toward incorporating nursing voices in discussions about the types of supports that are needed around the clock would make a step toward improving nurses’ ability to facilitate care to hospitalized older adults.

Two important implications for nursing education have been illuminated through the theory of orchestrating care. They include (a) tailoring basic education about older adult care so that it addresses the contexts in which nurses are applying their knowledge; and (b) providing opportunities for nurses to critically reflect on how they are learning from one another within impoverished care environments where they often feel limited in their options to provide care.

The findings of this study showed that novice nurses, even when they have had formal education about older adult care, are learning negative practices from more seasoned nurses about how to care for older adults within the challenging context of acute hospital environments. This nurse-to-nurse practice of knowledge transmission underscores the importance of new nurses graduating with the capacity to apply knowledge about older adult care to difficult practice situations. This will better enable them to exercise their agency in suggesting alternative strategies, rather than resorting to the negative practices they see enacted around them. It has been argued by others that basic nursing curricula need to include more gerontological content.
(Aud et al.; 2006; Baumbusch & Andrusyszyn, 2002; Baumbusch & Goldenberg, 2000; Holroyd et al., 2009; Ironside et al., 2010; King, 2004; Xiao et al., 2008). This study has gone a step further to highlight the importance of ensuring that nurses graduate not only with knowledge about older adult care, but also with the ability to apply that knowledge in a variety of challenging contexts, where in order to survive they also need to fit into the nursing team. Thus, these new graduates must also be equipped with strategies for applying evidence-based practices within existing nursing and interdisciplinary teams where others could be entrenched in established routines. At the same time, the findings of my study also support recent national recommendations that educators need to work together with nursing leaders to improve healthcare settings so they are a safe environment for students and novice nurses to suggest new evidenced-based practices to their more seasoned colleagues (Eggerton, 2013).

The theory of orchestrating care also suggests an opportunity for hospital-based nurse educators to play an important role in broadening the repertoire of strategies for nurses when they are caring for hospitalized older adults. Conducting forums where novice and seasoned nurses can openly discuss the challenges they face would provide an opportunity for nurses to understand the unintended negative consequences for both older adults and nurses’ workload when they engage in practices that may be undermining their goals of care. Educators could assist novice nurses in being able to practice the evidence-based knowledge they have learned in their education programs. They could also motivate nurses to manage challenging practice situations differently by highlighting how negative practices are actually increasing nurses’ workload, rather than minimizing their strain. Furthermore, through capitalizing on technology to provide ready access to evidence-based strategies, educators could support nurses by adding to their knowledge about how to address challenging situations in ways that acknowledge nurses’
need to assess information efficiently. Nurses who learn more effective strategies in managing older adult care will then be perpetuating these practices through their learning from one another within their social work environment. In these ways educators would be assisting nurses to minimize strain and enhance how nurses are orchestrating care.

The theory of orchestrating care offered novel insights about how nurses were building synergy with other nurses and with other healthcare professionals. These insights suggest that more inquiry is needed to better understand these complex issues around teamwork. Although research identifies that older adult care is improved when healthcare disciplines work collaboratively (Arbaje et al., 2010; Benedict et al., 2006; Boult et al., 2009), how to enact multidisciplinary teams to achieve the best outcome for patients is complex and poorly understood. My study has suggested that this is partly because nurses work different hours than other team members, and they believe their perspectives have less value in patient care decisions. In addition to examining these perspectives in forums, as has been discussed earlier, further research is needed to examine the dynamics of nursing care and multidisciplinary teams. A greater understanding of how team dynamics influence care delivery would enhance knowledge about how to best construct various healthcare teams in ways that would facilitate nurses in building synergy and ultimately enhance how care is delivered to hospitalized older adults.

Although there is recognition that an important element in providing safe and effective patient care is the right mix of healthcare providers (Health Canada, 2008), my study confirms Sears’ (2011) findings that the diversity of healthcare environments and changing patient acuity makes it challenging to determine what staff mix is needed at any given point in time. Scholars have identified that patient outcomes are influenced by hospital environments, the education level of the nurses (Aiken et al., 2008, 2011, 2012; Hall, Doran, & Pink, 2008), and the numbers
of nurses (McGillis Hall, Doran, & Pink, 2008; Manojlovich & Sidani, 2008; Mitchell, 2009; Sears, 2011); however, little to no research has examined LPNs’ or PCAs’ contributions to nursing care delivery teams (Harris & McGillis Hall, 2012; IOM, 2004). My study has shed light on how important nursing team interactions and reciprocity are to how nurses are building synergy, suggesting that more research is needed to better understand (a) how to more effectively orchestrate patient care within the nursing team, (b) how to foster a sense of reciprocity in teams comprised of care providers with different scopes of practice, (c) how to foster relationships among multidisciplinary team members, and (d) how to explicate unspoken expectations that influence how nurses are orchestrating care within healthcare teams.

The findings from this study suggest that governmental policies that reward hospitals when they promote admission of patients from emergency departments have had an unintended impact of increasing overcapacity on inpatient units and increasing the numbers of admissions during evenings and nights when there are few supports to effectively manage the care needs of these patients. Overcapacity and admissions outside of regular office hours have made it more difficult for nurses to orchestrate care. The findings from this study can help to inform the Canadian Nurses Association and other nursing associations that are advocating for policies that support nursing practice with older adults. The issues are complex, and therefore policies that support older adult care require thoughtful engagement of nurses in developing solutions that will be more likely to address the many layers of the issues. Policies that increase nurses’ access to basic equipment and resources around the clock, that attend to nurses’ voices in patient care issues within healthcare teams, and that support adequate professional nursing care at the bedside would go a long way to enhancing care of hospitalized older adults.
7.7 Conclusions

In the preceding chapters, I have explained the complexity of nursing practice with hospitalized older adults through the theory of orchestrating care. This theory has explained nurses’ good intentions in providing care for older adults, how they engage in many strategies to provide what they perceive as good care in contexts they describe as ill-equipped to support them, and how they manage their moral distress resulting from engaging in negative practices. I have used the symbolism of orchestrating care within a siege mentality to explain how nurses were viewing the healthcare system as the cause of their problem in providing good care for their hospitalized older adults, while still sustaining themselves as good nurses. While there is much evidence to support that system issues are influencing nursing practice with hospitalized older adults, nurses’ responses to these concerns are inadvertently contributing to their challenges.

I have discussed four key issues that highlight the complexity of how nurses’ responses to their concerns are contributing to their challenges. The first issue illuminated how nurses’ attempts to quickly describe their patients and assign resources according to acute needs have resulted in nurses’ uncritical use of the term heavy to describe their older patients with functional issues. This term does not capture the nuances of complexity of these patients; as a result, these heavy patients often experience detrimental consequences and take longer to recover, which contributes to increased workload demands for nurses. The second issue explained how nurses who are feeling pressured by their responsibilities and the expectations of others look to their nurse colleagues as their allies, often viewing others as adversaries. This inward gaze, or siege mentality, is a barrier to building synergy with others, prevents nurses from articulating their challenges to their managers, and from looking for new ways to work together as a nursing team. The third issue illuminated the complexity of keeping patients safe in environments that nurses
defined as constrained. Safety was defined in narrow ways and enacted through negative practices, such as physical and chemical restraints, thus contributing to poor patient outcomes and nurses’ moral distress. The final issue explained how nurses were managing their moral distress from falling short of their goals by reframing negative practices as positive in order to sustain themselves as good nurses.

In conclusion, the theory of orchestrating care has offered an explanation of the complexity of the issues associated with nursing practice of older adults in hospitals. It has also highlighted the importance of nurses’ role in caring for this population. Thus it is essential that nurses are encouraged to voice their practice challenges and that leaders, educators, and policy analysts listen to practicing nurses in order to collaboratively consider a way forward. Solutions that will advance care of hospitalized older adults must consider the complexity associated with the challenges nurses face in their efforts to provide good care and sustain themselves as good nurses.
REFERENCES


Canadian Institute for Health Information. (2011). *Seniors and the health care system: What is the impact of multiple chronic conditions?* Ottawa, Canada: Author.


APPENDICES
Appendix A: Definition of Terms

Nurse: A nurse is an individual who is responsible for the care of patients through healthcare agencies and in healthcare institutions. Care, in this context, is a verb that denotes actions toward the betterment of patients’ conditions or situation.

Patients: Patients are the care recipients within the health care agency or healthcare institution.

RN: RN is the abbreviation for Registered Nurse. RNs are professional healthcare workers who have been formally educated a minimum of two to four years, and are accountable to the public through a professional association. Their scope of practice includes caring for stable and unstable populations.

LPN: LPN is the abbreviation for Licensed Practical Nurses. LPNs are professional health care workers who have been formally educated for at least one year and are accountable to the public through a professional association. Their scope of practice includes caring for stable populations.

PCA: PCA is the abbreviation for a Patient Care Aide. PCAs are healthcare workers who have received education for up to six months. Their scope of practice includes the basic physical care needs of individuals. They do not belong to a professional association and work under the direction of either an RN or an LPN.
Older Adult: For the purposes of this study individuals over the age of sixty-five were considered older adults. This is because in Canada and other developed countries retirement age and the beginning of old age is associated with age sixty-five, or there-about (Center for Association on Mental Health (CAMH), 2012).
Appendix B: Poster
Research study about how nurses work with older adults

Learning about how nurses work with older people can provide information about supporting nurses in giving the best possible care to older adults.

A graduate student from the UBC School of Nursing is observing and talking with nurses on this unit about their work with older adults.

The research also includes the nurses’ interactions with patients, their families, and other health care professionals.

For more information or to volunteer for this study, contact Sherry Dahlke
Appendix C: Information Cards
How do nurses work with older people?

A student from the UBC School of Nursing is doing research to observe how nurses care for older adults.

The results of this research will be used to support nurses in giving the best possible care to older adults.

For further information or to participate in this research contact:
Sherry Dahlke at [email protected] or [phone number]
You are invited to take part in a research study examining how nurses work with older adults

WHY IS THE RESEARCH BEING DONE?
Learning about how nurses work with older people can provide information about supporting nurses in giving the best possible care to older adults.

WHAT DOES THE RESEARCH INCLUDE?
The researcher will be observing nurses while they work and conducting interviews to explore how nurses perceive their practice with older people.

HOW CAN YOU HELP?
If you are an RN, LPN, or care aide who has worked with older adults for at least six months, you are invited to take part in this research.

FOR FURTHER INFORMATION CONTACT:
Sherry Dahlke at [contact information] or [contact information]
How do nurses work with older people?

A student from the UBC School of Nursing is doing research to observe how nurses care for older adults.

The results of this research will be used to support nurses in giving the best possible care to older adults.

For further information or to participate in this research contact: Sherry Dahlke at [redacted] or [redacted]
Be a part of a research study examining how nurses work with older people

WHY IS THE RESEARCH BEING DONE?
Learning about how nurses work with older people can provide information about supporting nurses in giving the best possible care to older adults.

WHAT DOES THE RESEARCH INCLUDE?
The researcher will be observing nurses while they work. This includes observing their interactions with patients, family members and other health care professionals.

HOW CAN YOU HELP?
Your participation would allow the researcher to include the nurses’ interactions with you as part of the research.

FOR FURTHER INFORMATION CONTACT:
Sherry Dahlke at [redacted] or [redacted]
Appendix D: Nurse Participant Consent Forms

Nursing older adults: Making meaning of complex practice
Consent Form for Nurse Participants

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators:
Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose:
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You have been invited to take part in this research because you are a nurse who works in a hospital with older adults.
Study Procedures:
If you agree to participate in this study, a researcher will observe you while you work for two or more of your regular shifts and conduct an interview with you at a later time to discuss your work with older people.

When the researcher is observing you, she may ask you brief questions about what you are doing and may write notes about your responses. These questions will occur when it is a convenient time for you. The researcher may also be writing notes about what she is observing as you do your work.

The interview will be audio-recorded and will take approximately 20 - 90 minutes. It will occur at a time and place that is mutually agreeable to you and the researcher. In this confidential interview, the researcher will ask you questions about your experiences with hospitalized older adults. The researcher may ask to interview you a second time at a later date in order to clarify some of your previous responses.

Potential Risks:
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your work and ask questions. Those observations and conversations with you will be held in strict confidence. There is also a remote possibility that you may experience some emotional discomfort when sharing difficult experiences from your work. If you become distressed, you could contact your hospital employee assistance program for counseling.

Potential Benefits:
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults. You may also experience some benefit from the opportunity to talk about your nursing experiences.

Confidentiality:
The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study while you are allowing the researcher to observe your work. All of the researcher’s observations, notes, and conversations with you will be kept confidential. All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the notes and transcribed data. Participants will be identified by pseudonyms. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [contact information] or via email at [email address].

**Contact for concerns about the rights of research subjects:**
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at [contact information] or if long distance, e-mail to [email address].

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment. If you wish to withdraw from the study at any point your data will be removed from the study.

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

Your signature indicates that you consent to participate in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name
Nursing older adults: Making meaning of complex practice
Consent Form for Nurse Participants

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators:
Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

Marcia Carr
Clinical Nurse Specialists- Acute Geriatrics, Geropsychiatry
Fraser Health- Burnaby Hospital

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

You are being invited to take part in this research study because you are a nurse who works with hospitalized older adults. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts. If you wish to participate, you will be asked to sign this from. If you do
decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will your employment or advancement within Fraser Health be compromised in any way if you choose not to participate, or if you choose to withdraw from the study. Please take the time to read the following information carefully and discuss it with your family, and friends before you decide.

**Purpose:**
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You have been invited to take part in this research because you are a nurse who works in a hospital with older adults.

**Study Procedures:**
If you agree to participate in this study, a researcher will observe you while you work for two or more of your regular shifts and conduct an interview with you at a later time to discuss your work with older people.

When the researcher is observing you, she may ask you brief questions about what you are doing and may write notes about your responses. These questions will occur when it is a convenient time for you. The researcher may also be writing notes about what she is observing as you do your work.

The interview will be audio-recorded and will take approximately 20 - 90 minutes. It will occur at a time and place that is mutually agreeable to you and the researcher. In this confidential interview, the researcher will ask you questions about your experiences with hospitalized older adults. The researcher may ask to interview you a second time at a later date in order to clarify some of your previous responses.

**Potential Risks:**
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your work and ask questions. Those observations and conversations with you will be held in strict confidence. There is also a remote possibility that you may experience some emotional discomfort when sharing difficult experiences from your work. If you become distressed, you could contact your hospital employee assistance program for counseling.

**Potential Benefits:**
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults. You may also experience some benefit from the opportunity to talk about your nursing experiences.

**Confidentiality:**
Your confidentiality will be respected. You will be assigned a unique study number. Only this will be used on any research-related information, including medical records, personal data and research data, collected about your during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be
kept confidential. The findings of this study that has any identifying information removed will be shared in professional and scholarly journals and presentations.

Information that directly discloses your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.

No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records and medical records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the FH Research Ethics Board for the purpose of monitoring the research. These personnel are required to keep your identity and personal information confidential. However, no records, which identify you by name, will be allowed to leave the Investigators’ offices.

The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study while you are allowing the researcher to observe your work. All of the researcher’s observations, notes, and conversations with you will be kept confidential. All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the notes and transcribed data. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection for five years after which time they will be destroyed.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [contact information removed] or via email at [contact information removed].

**Contact for concerns about the rights of research subjects:**
If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact wither Dr. Marc Folkes or Dr. Allan Belzberg, REB co-Chairs by calling [contact information removed]. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. If you have any concerns about your treatment or rights as a research subject, you may also contact the Research Subject Information Line in the UBC Office of Research Services at [contact information removed] or if long distance, e-mail to [contact information removed].

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment. If you wish to withdraw from the study at any point your data will be removed from the study. By signing this form, you do not give up any of your legal rights and you do not release the study investigator or other participating institutions from their legal and professional duties.
Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

____________________________________________________
Witness (Principal investigator/designate)
Nursing older adults: Making meaning of complex practice
Consent Form for Bystander Participants

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators:
Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose:
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because you work on a unit where this study is taking place. The researcher is interested in what the nurses are doing and saying during their work with older people. Nurses’ work can also include talking to other nurses and other health care professionals.
Study Procedures:
If you agree to participate, the researcher’s observations of your interactions with participating nurses will be included in the study. This means the researcher may take notes about the nurses’ interactions with you and about your responses to the nurses.

The researcher may want to talk to you further about your interactions with nurses. Thus, you may be asked if you are willing to participate in an audio-recorded interview of approximately 20 - 90 minutes at a later time. This interview would occur at a time and place that is mutually agreeable to you and the researcher.

Potential Risks:
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your work and ask questions. Those observations and conversations with you will be held in strict confidence.

Potential Benefits:
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults. You may also experience some benefit from the opportunity to talk about your interactions with nurses and older people.

Confidentiality:
The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study while you are allowing the researcher observe your interactions with the nurse participants. All of the researcher’s observations, notes, and conversations with you will be kept confidential. You will be identified in the researcher’s notes by a pseudonym.

All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the notes and transcribed data. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

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If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at [contact information] or if long distance e-mail to [contact information].
Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy. If you wish to withdraw from the study at any point your data will be removed from the study.

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

Your signature indicates that you consent to allow your interactions with nurses to be included in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

Your signature (below) indicates that you consent to be interviewed for this study.

____________________________________________________
Subject Signature     Date
Nursing older adults: Making meaning of complex practice
Consent Form for Bystander Participants

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators: Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
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University of British Columbia School of Nursing

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Marcia Carr
Clinical Nurse Specialists- Acute Geriatrics, Geropsychiatry
Fraser Health- Burnaby Hospital

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

You are being invited to take part in this research study because you are a health care professional who works with nurses and hospitalized older adults. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts. If you wish to participate, you will be asked to sign this from. If you do decide to take part in this study, you are still free to withdraw.
at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will your employment or advancement within Fraser Health be compromised in any way if you choose not to participate, or if you choose to withdraw from the study. Please take the time to read the following information carefully and discuss it with your family, and friends before you decide.

Purpose:
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because you work on a unit where this study is taking place. The researcher is interested in what the nurses are doing and saying during their work with older people. Nurses’ work can also include talking to other nurses and other health care professionals.

Study Procedures:
If you agree to participate, the researcher’s observations of your interactions with participating nurses will be included in the study. This means the researcher may take notes about the nurses’ interactions with you and about your responses to the nurses.

The researcher may want to talk to you further about your interactions with nurses. Thus, you may be asked if you are willing to participate in an audio-recorded interview of approximately 20 - 90 minutes at a later time. This interview would occur at a time and place that is mutually agreeable to you and the researcher.

Potential Risks:
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your work and ask questions. Those observations and conversations with you will be held in strict confidence.

Potential Benefits:
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults. You may also experience some benefit from the opportunity to talk about your interactions with nurses and older people.

Confidentiality:
Your confidentiality will be respected. You will be assigned a unique study number. Only this will be used on any research-related information, including medical records, personal data and research data, collected about your during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. The findings of this study that has any identifying information removed will be shared in professional and scholarly journals and presentations.

Information that directly discloses your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.
No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records and medical records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the FH Research Ethics Board for the purpose of monitoring the research. These personnel are required to keep your identity and personal information confidential. However, no records, which identify you by name, will be allowed to leave the Investigators’ offices.

The identity of all participants will be kept strictly confidential. However, since your work is involved with other healthcare workers, they may be aware of your participation in the study while you are allowing the researcher observe your interactions with the nurse participants. All of the researcher’s observations, notes, and conversations with you will be kept confidential. You will be identified in the researcher’s notes by a pseudonym.

All audio-taped interviews will be transcribed and all identifiers (such as names and places) will be removed from the notes and transcribed data. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection for five years after which time they will be destroyed.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [redacted] or via email at [redacted].

Contact for concerns about the rights of research subjects:
If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact wither Dr. Marc Folkes or Dr. Allan Belzberg, REB co-Chairs by calling [redacted]. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. If you have any concerns about your treatment or rights as a research subject, you may also contact the Research Subject Information Line in the UBC Office of Research Services at [redacted] or if long distance e-mail to [redacted].

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy. If you wish to withdraw from the study at any point your data will be removed from the study. By signing this form, you do not give up any of your legal rights and you do not release the study investigator or other participating institutions from their legal and professional duties.
Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to allow your interactions with nurses to be included in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

____________________________________________________
Witness (Principal investigator/designate)

Your signature (below) indicates that you consent to be interviewed for this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

____________________________________________________
Witness (Principal investigator/designate)
Nursing older adults: Making meaning of complex practice
Consent Form for Patients

**Principal Investigator:**
Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

**Co-Investigators:**
Sherry Dahlke
PhD candidate
University of British Columbia School of Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

**Purpose:**
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because you are a patient on a unit where this study is taking place. This means that a researcher may be observing some of the nurses who are caring for you while they work. The researcher is interested in what the nurses are doing and what they are saying during their work with older people.
Study Procedures:
If you agree, the researcher’s observations of your nurses’ interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, what you say and do in response.

Potential Risks:
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse. Those observations and conversations will be held in strict confidence.

Potential Benefits:
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

Confidentiality:
The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [redacted] or via email at [redacted].

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at [redacted] or if long distance e-mail to [redacted].

Consent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to you as a patient. If you wish to withdraw from the study at any point your data will be removed from the study.
Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Subject Signature __________________________ Date __________

Printed Name __________________________

If you are a designated decision maker who is signing on behalf of the research participant, please complete the box below

I consent to ___________________________ ‘s participation in this study.

                          (printed name of the research participant)

Signature __________________________ Date __________

(Designated Decision maker)

Printed Name of Designated Decision maker __________________________
Nursing older adults: Making meaning of complex practice
Consent Form for Patients

Principal Investigator: Dr. Alison Phinney
Associate Professor
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This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

You are being invited to take part in this research study because you are a hospitalized older adult. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts. If you wish to participate, you will be asked to sign this form. If you do decide to take part in this study, you
are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will you lose the medical care to which you are entitled or are presently receiving. Please take the time to read the following information carefully and discuss it with your family, friends, and doctor before you decide.

**Purpose:**
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because you are a patient on a unit where this study is taking place. This means that a researcher may be observing some of the nurses who are caring for you while they work. The researcher is interested in what the nurses are doing and what they are saying during their work with older people.

**Study Procedures:**
If you agree, the researcher’s observations of your nurses’ interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, what you say and do in response.

**Potential Risks:**
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse. Those observations and conversations will be held in strict confidence.

**Potential Benefits:**
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

**Confidentiality:**
Your confidentiality will be respected. You will be assigned a unique study number. Only this will be used on any research-related information, including medical records, personal data and research data, collected about your during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. The findings of this study that has any identifying information removed will be shared in professional and scholarly journals and presentations.

Information that directly discloses your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.

No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records and medical records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the FH Research Ethics Board for the purpose of monitoring the research. These personnel
are required to keep your identity and personal information confidential. However, no records, which identify you by name, will be allowed to leave the Investigators’ offices.

The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection for five years after which time they will be destroyed.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [Contact Information] or via email at [Contact Information].

**Contact for concerns about the rights of research subjects:**
If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact wither Dr. Marc Folkes or Dr. Allan Belzberg, REB co-Chairs by calling [Contact Information]. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. If you have any concerns about your treatment or rights as a research subject, you may also contact the Research Subject Information Line in the UBC Office of Research Services at [Contact Information] or if long distance e-mail to [Contact Information].

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to you as a patient. If you wish to withdraw from the study at any point your data will be removed from the study. By signing this form, you do not give up any of your legal rights and you do not release the study investigator or other participating institutions from their legal and professional duties.

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

Your signature indicates that you consent to participate in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

If you are a designated decision maker who is signing on behalf of the research participant, please complete the box on the next page.

____________________________________________________
Witness (Principal investigator/designate)

Version: FHREB 2010-041. June 2010
I consent to ____________________________ ‘s participation in this study.
(printed name of the research participant)

____________________________________________________
Signature     Date
(Designated Decision maker)

___________________________________________________
Printed Name of Designated Decision maker

___________________________________________________
Witness (Principal investigator/designate)
Appendix G: Chinese Forms
護士怎樣為老人家服務？

卑詩大學護理學院(UBC School of Nursing)
一名學生現正進行研究，觀察護士怎樣照顧長者。

這項研究的結果將會用於支持護士給予長者盡可能最好的護理。

欲知詳情或參加這項研究，請聯絡：Sherry Dahlke，電話**或電郵**
參與一項探討護士怎樣為老人家服務的研究

為什麼進行這項研究？
了解護士怎樣為老人家服務，可提供有關支持護士給予長者盡可能最好的護理的資料。

這項研究包括什麼？
研究人員將會在護士工作期間觀察他們。這方面包括觀察他們與病人、家人及其他醫護人員的互動。

您可怎樣幫忙？
您的參與會讓研究人員可以把護士與您的互動納入這項研究內。

欲知詳情，請聯絡：
Sherry Dahlke，電話或電郵。
照料長者：理解複雜實務的意義
病人同意書 (Consent Form for Patients)

首席研究員：
Dr. Alison Phinney
卑詩大學護理學院 (University of British Columbia School of Nursing)
副教授 (Associate Professor)

共同研究員：
Sherry Dahlke
卑詩大學護理學院
博士生 (PhD candidate)

Dr. Wendy Hall
卑詩大學護理學院
教授 (Professor)

Dr. Paddy Rodney
卑詩大學護理學院
副教授

Dr. Jennifer Baumbusch
卑詩大學護理學院
助理教授 (Assistant Professor)

這項研究是為了滿足 Sherry Dahlke 的博士論文的要求。研究結果將於會議及期刊裏公諸於世，用於臨床及研究方面的應用。這項研究的參加者也將會獲發研究結果的摘要。

目的：
這項研究是要探討護士怎樣為住院的長者服務，以及其他方面的工作的因素。您被要求在這些同意書，因為你在進行這項研究的部門的病人。換言之，研究人員可能會在一些照顧您的護士工作期間觀察他們。研究人員想知道護士在為老人家服務期間做什麼和說什麼。

Nursing older adults: Making meaning of complex practice
Consent Form for Patients [Chinese Traditional]
Version: March 2010
研究程序:
如果您同意，研究人員對護士與您的互動的觀察，將會納入研究內。換言之，研究人員可能會記下護士說什麼或做什麼，以及您說什麼和做什麼作為回應。

可能有的風險:
參與這項研究對您造成的風險是少之又少。您可能會因為有研究人員觀察您與護士的互動而失去私隱。這些觀察和對話將會絕對保密。

可能有的好處:
雖然並無即時的好處，但您參與這項研究，將會有助更深入了解長者護理實務。

保密:
所有參加者的身份都會絕對保密。在研究人員的筆記裏您會以另一(虛構)名字作為識別，而任何可能公開您的身份的資料都會更改。所有資料記錄均存放在位於安全地點的一個上了鎖的文件櫃內，以及有密碼保護的電腦裏。

想取得有關這項研究的資料，請聯絡:
如有任何問題或想取得更多有關這項研究的資料，您可聯絡Sherry Dahlke，電話：********，或電郵至********。

在研究對象的權利方面如有憂慮，請聯絡:
如對自己作為研究對象所受到的對待或享有的權利方面有任何憂慮，您可聯絡卑詩大學研究服務處(UBC Office of Research Services)的研究對象資訊專線(Research Subject Information Line)，電話********，或者如果是長途的話可電郵至********。

同意:
參與這項研究純屬自願性質，您可拒絕參加或隨時退出這項研究，而不會對您作為病人有任何損害。任何時間如果您想退出這項研究，您的資料將會從研究中刪除。

您在下面簽名，是表示您已收到這份同意書的副本以作紀錄。

您的簽名表示您同意參加這項研究。

研究對象簽名  日期

姓名正寫
如果您是代表研究對象簽署的指定代決人，請填妥下面的方格。

<table>
<thead>
<tr>
<th>我同意 ___________________________________________ 參加這項研究。</th>
</tr>
</thead>
<tbody>
<tr>
<td>(研究對象的姓名正寫)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>簽名</td>
</tr>
<tr>
<td>(指定代決人)</td>
</tr>
</tbody>
</table>

指定代決人的姓名正寫
照料長者：理解複雜實務的意義
病人同意書

首席研究員：
Dr. Alison Phinney
卑詩大學護理學院(University of British Columbia School of Nursing)
副教授(Associate Professor)

共同研究員：
Sherry Dahlke
卑詩大學護理學院
博士生(PhD candidate)

Dr. Wendy Hall
卑詩大學護理學院
教授(Professor)

Dr. Paddy Rodney
卑詩大學護理學院
副教授

Dr. Jennifer Baumbusch
卑詩大學護理學院
助理教授(Assistant Professor)

Marcia Carr
菲沙衛生局(Fraser Health) - 本那比醫院(Burnaby Hospital)
老年精神病學急症老人科 - 專科護理師(Clinical Nurse Specialist)

這項研究是為了滿足Sherry Dahlke的博士論文的要求。研究結果將於會議及期刊表達其於世，
作臨床和研究方面的應用。這項研究的參加者也將會獲發研究結果的摘要。

您獲邀請參加這項研究，因為您是住院的長者。您的參與純屬自願性質，因此是否參加這項研
究，由您決定。在作決定前，您必須明白這項研究涉及什麼。這份同意書會讓您知道這項研究的

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內容，為何進行這項研究，在研究期間您的情況會怎樣，以及可能有的好處、風險和不適。如果您想參與，您會被要求簽署這份同意書。如果您真的決定參加這項研究，您仍可隨時退出，並且不必解釋您的決定。如果您不想參與，您毋須說出不參與的原因，也不會失去您有權得到或現正接受的醫療。請抽時間仔細閱讀以下資料，並與家人、朋友及醫生商量，之後才作決定。

目的：
這項研究是要探討護士怎樣為住院的長者服務，以及影響這方面的工作的因素。您被要求簽署這份同意書，因為您是在進行這項研究的部門的病人。換言之，研究人員可能會在一些照顧您的護士工作期間觀察他們。研究人員想知道護士在為老人家服務期間做什麼和說什麼。

研究程序：
如果您同意，研究人員對護士與您的互動的觀察，將會納入研究內。換言之，研究人員可能會記下護士說什麼和做什麼，以及您說什麼和做什麼作為回應。

可能有的風險：
參與這項研究會對您造成的風險是少之又少。您可能會因為有研究人員觀察您與護士的互動而失去私隱。這些觀察和對話將會絕對保密。

可能有的好處：
雖然並無即時的好處，但您參與這項研究，將會有助更深入了解長者護理實務。

保密：
您的保密將會受到尊重。您會獲分配一個獨特的研究編號。在這項研究期間收集得您的與研究有關的資料，包括醫療記錄、個人資料及研究資料，只會用這個編號，於是你作為這項研究的對象這個身份[即是您的姓名或可能公開您身份的其他資料]將會保密。這項識別資料會被删除的研究結果，將會在專業及學術期刊和簡報中公諸於世。

只有首席研究員及/或其指派人選才可接觸到直接披露您身份的資料。將您的姓名與獨特識別符配對起來的名單，如未經您得知及同意，將不會發佈，除非法律或條例規定要這樣做。獨特識別符是用於您的與研究有關的資料。

任何會披露您身份的資料，如未得您明確同意作披露，將不會發佈或公開。然而，會使您身份公開的研究記錄及醫療記錄，可能會在研究人員或其指定人選面前，受到菲沙衛生局研究操守委員會(FH Research Ethics Board)的代表審查，作為監察研究之用。這些人員必須將您的身份及個人資料保密。不過，任何會指名道姓公開您身份的記錄，都不得離開研究人員的辦公室。

所有參加者身份都會絕對保密。在研究人員的筆記裏您會以另一(虛構)名字作為識別，而任何可能公開您的身份的資料都會更改。所有資料記錄均存放在位於安全地點的一個上了鎖的文件櫃內，以及有密碼保護的電腦裏，為期五年，之後就會銷毀。
想取得有關這項研究的資料，請聯絡：
如有任何問題或想取得更多有關這項研究的資料，您可聯絡Sherry Dahlke，電話[聯絡電話]，
或電郵至[電郵地址]。

在研究對象的權利方面如有憂慮，請聯絡：
如對自己作為研究對象的權利及/或在參與這項研究期間的體驗方面有任何憂慮或投訴，您可致電[聯絡電話]，聯絡研究操守委員會(REB)共同主席Dr. Marc Folkes或Dr. Allen Belzberg。
您可與菲沙衛生局REB這兩位主席其中一位商討您的權利。如對自己作為研究對象所受到的對待或享有的權利方面有任何憂慮，您也可聯絡卑詩大學研究服務處(UBC Office of Research Services)的研究對象資訊專線(Research Subject Information Line)，電話：[聯絡電話]，或者如果是長途的話可電郵至[電郵地址]。

同意：
參與這項研究純屬自願性質，您可拒絕參加或隨時退出這項研究，而不會對您作為病人有任何損害。任何時間如果您想退出這項研究，您的資料將會從研究中刪除。簽署這份同意書，並沒有使您放棄您的法定權利，您也沒有免除研究人員或其他參與機構的法律及專業責任。

您在下面簽名，是表示您已收到這份同意書的副本以作紀錄。

您的簽名表示您同意參加這項研究。

研究對象簽名 日期

姓名正寫
如果您是代表研究對象簽署的指定代決人，請填妥下一頁的方格。

見證人(首席研究員/其指派人選)
我同意________________________________________参加这项研究。
（研究对象的姓名正写）

________________________________________
签名
（指定代表人）

________________________________________
指定代表人的姓名正写

________________________________________
见证人（首席研究员/指派人选）
照料長者：理解複雜實務的意義
家人同意書(Consent Form for Family Members)

首席研究員：
Dr. Alison Phinney
卑詩大學護理學院
副教授(Associate Professor)

共同研究員：
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研究程序:
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保密:
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如對自己作為研究對象所受到的對待或享有的權利方面有任何憂慮，您可聯絡卑詩大學研究服務處(UBC Office of Research Services)的研究對象資訊專線(Research Subject Information Line)，電話：******，或者如果是長途的話可電郵至**********。

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參與這項研究純屬自願性質，您可拒絕參加或隨時退出這項研究，而不會對您或家人有任何損害。任何時間如果您想退出這項研究，您的資料將會從研究中刪除。

您在下面簽名，是表示您已收到這份同意書的副本以作紀錄。

您的簽名表示您同意參加這項研究。

研究對象簽名    日期

姓名正寫

Nursing older adults: Making meaning of complex practice
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Appendix H: Punjabi Forms
ਤਿੰਨ ਵਨਓਂ ਤਲਾਂ ਵੀਨ ਵਿੱਚ ਵਗਤੀਆਂ ਗਏ?

ਗੁਢ ਸੀ ਸਾਤ ਮੁੱਲਾਂ ਅਗੇ ਤਨਵੀਨ ਤੇ ਦਿੱਲ ਦੀ ਸਕੀਲ ਪੈਦਾ ਕਰਨ ਵਾਲੀ ਹੈ ਤਿੰਨ ਵਨਓਂ ਤਲਾਂ ਵਿੱਚ ਵਗਤੀਆਂ ਗਏ।

ਦਿੱਲ ਭੇਣਾ ਹੋਇਆ ਹੋਇਆ ਤਨਵੀਨ ਤੇ ਟੋਟਨਾ, ਵਨਓਂ ਦੀ ਟੀਪ ਚੇਨ ਰੱਖਣ ਵਾਲਾ ਹੋਇਆ ਤਲਾਂ ਦੀ ਅੱਠ ਵਗਤੀ ਲਿੱਤੀ ਵੀਡੀਓ ਵੇਅੀ।

ਤਿੰਨ ਵਨਓਂ ਤਲਾਂ ਵਗਤੀਆਂ ਦਾ ਦਿੱਲ ਦਿੱਲ ਦਿੱਲ ਦਿੱਲ ਸਟੈਟ ਕਾਉਕ ਵਗਤ ਲਿਖ ਵਨਓਂ ਦੀ ਅੱਠ ਵਗਤੀ ਲਿੱਤੀ ਵੀਡੀਓ ਵੇਅੀ।

ਉੱਰ ਸ੍ਰੀਮਾਨ ਲਈ ਹਿੱਚ ਤਲਾਂ ਦਾ ਦਿੱਲ ਦਿੱਲ ਦਿੱਲ ਦਿੱਲ ਲਿੱਤੀ ਸੈਂਟਰ ਵੇਅੀ:
ਮੈਣੀ ਹਿੱਚਵਾਨੀ ਸਾਲੋਂ 2004 'ਤੇ ਸੀ
2009 'ਤੇ।
सत्सं बलमुकां राल बल बिदें वजसीरां उठ सं दे ये पेन
अपनामें दा जिमा बहे

कितने किसीं बीडी ना बाती है?
कितन पढ़ा लाभद राल बि तत्सं बलमुकां राल बल बिदें वजसीरां उठ, बलमुकां दी हैं डैप डैप डैप डैप
dैप डैप डैप मंडाल वजसे बित तत्सं दी भजन बजते धाने महत्त्वानी भित बजती है।

कितने किन्तु ही मञ्जरी है?
कितन बजते दर्शी दुम डेले तत्सं दू किसी भाव राल देखेगी नते बीजे बीजे वजसीरां रेडातीगीं।
कितन किसीं नन्हुं का भवेगा, बहिरात दे मंडाल अभे बिलम वजसे बजते धाने तत भावनें राल देहाएहूँ
‘डे रिहुएँ’ रेहुएँ मञ्जरी है।

उसीं भजन बिदें बज मबदे है?
उसीं महुलिअउड़, कितन बजते दर्शी ठूँ किसे दे लिंगे इसे तत्सं दे डैपदे राल देहाएहूँ रेडाट देहेगी।

बेव महत्त्वानी की पद पद किमच पक्षवते हैं:
बैंदी डांसले राल [***] डे सो [***] 'डे।
Consent Form for Patients [Punjabi]
Version: March 2010
एपिफ़ोल एवं अन्योन्य:

मूल्यांकन के लिए, हमें उपकरण और उपकरणों का तहत करना होता है जो नस्ल में रखना चाहिए। अन्य उपकरण जिसमें हैं हमें उपकरण नहीं करना होता है। इस तरह से नस्ल में रखना चाहिए।

मूल्यांकन विधि:

हमारे मूल्यांकन विधि और उपकरण भिन्न बांट चुके हैं। उपकरण में रखना चाहिए और नस्ल में रखना होता है। बांट चुके शरीर में रखना चाहिए।

मूल्यांकन प्रणाली:

इस तरह से नस्ल में रखना चाहिए।

चेतनाएँ:

नेत्रांकित लेखन के साथ नस्ल के रूप में रखना चाहिए।

मूल्यांकन विधि और उपकरण का उपयोग:

हमारे मूल्यांकन विधि और उपकरण का उपयोग करना चाहिए। इस तरह से नस्ल के रूप में रखना चाहिए।

मूल्यांकन विधि:

हमारे मूल्यांकन विधि और उपकरण भिन्न बांट चुके हैं।

नेत्रांकित लेखन के साथ नस्ल के रूप में रखना चाहिए।
से हुमारे दूसरे वर्तमान में यह वस्तुएँ या विभिन्न डायमेंट लाइव की होती है उनमें समाधान रख दें और विकास वर्तमान स्थिति में उन्हें भरते है।

| मैं _______________ दे मिम भविष्यवादिता फॉल माइल एंड दी माउंटगोरी पिया/सिंटो दृ।  |
| (पेन हिस्पिमा हैट रूपरूप संदेह आकार हिस्टा) |
| समाधान उत्तरी द्र (दैमल्ल वर्तमान लाइव चंडी निम्नलिखित) |
| दैमल्ल वर्तमान लाइव चंडी निम्नलिखित संदेह आकार हिस्टा |

Nursing older adults: Making meaning of complex practice
Consent Form for Patients [Punjabi]
Version: March 2010
ਨੂੰ ਗਲਤਾਂ ਦੀ ਮਸ਼ਹੂਰ ਵਿਦਵਾਨੀਵਾਂ ਦੇ ਅਧਾਰ ਸਹਿਤਾ ਅਧੀਨ ਸਥਾਨੀ ਮੰਨੀ ਵਾਲੀ ਵਿਦਵਾਨੀ ਵਾਰਾਂ

ਭੂਤਵਾਨਾ ਦਿਗ ਕੇਂਦਰਾਂ: ਵਿਦਵਾਨੀਵਾਂ ਦੇ ਅਧਾਰ ਸਹਿਤਾਂ ਅਧੀਨ ਸਥਾਨੀ ਮੰਨੀ ਵਾਲੀ ਵਿਦਵਾਨੀ ਵਾਰਾਂ

ਪ੍ਰਧਾਨ ਵੈਦਵਾਨਾ: ਵਿਦਵਾਨੀ ਵਾਰਾਂ
ਪ੍ਰਧਾਨ ਵੈਦਵਾਨਾ ਦਿਗ ਵਿਦਵਾਨੀ ਵਾਰਾਂ

ਸੰਵਾਦ ਵੈਦਵਾਨਾ: ਵਿਦਵਾਨੀ ਵਾਰਾਂ
ਪ੍ਰਧਾਨ ਵੈਦਵਾਨਾ ਦਿਗ ਵਿਦਵਾਨੀ ਵਾਰਾਂ

ਭਾਸ਼ਾ ਵਿਦਵਾਨ ਵਾਰਾਂ
ਵਿਦਵਾਨੀ ਵਾਰਾਂ

ਦਿਗ ਵੇਸ ਵੀਦਵਾਨਾ ਦੇ ਹੋ ਜੋ ਅਧਿਕਾਰ ਵੀਦਵਾਨ ਵੀਦਵਾਨ ਵਾਰਾਂ

ਦਿਗ ਵੇਸ ਵੀਦਵਾਨਾ ਦੇ ਹੋ ਜੋ ਅਧਿਕਾਰ ਵੀਦਵਾਨ ਵੀਦਵਾਨ ਵਾਰਾਂ

ਦਿਗ ਵੇਸ ਵੀਦਵਾਨਾ ਵਾਰਾਂ

ਦਿਗ ਵੇਸ ਵੀਦਵਾਨਾ ਵਾਰਾਂ

ਦਿਗ ਵੇਸ ਵੀਦਵਾਨਾ ਵਾਰਾਂ
Nursing older adults: Making meaning of complex practice
Consent Form for Patients [Punjabi]
Version: FHREB 2010-041. June 2010
Nursing older adults: Making meaning of complex practice
Consent Form for Patients [Punjabi]
Version: FHREB 2010-041. June 2010
मैं _____________________________ दे टिम अधिकृत विच मामल ढंठ दी
(भें विच विमा ढंठ बैठे सा दंडे अंदर विच रहे)
मधुरी दिंज़/दिंसी ना।

समुद्रहव | दरजी
(दैम्य वर्तन लहरी वापिस विधवाड़ी)

दैम्य वर्तन लहरी घरे विधवाड़ी रा दंडे अंदर विच रहे

श्रीमान (भें वेंबरवाट/विजवाट विधवाड़ी)
Appendix I: Patient Assent Forms

Nursing older adults: Making meaning of complex practice
Assent Form for Patients

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators: Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose:
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. This means that a researcher may be observing some of the nurses who are caring for you while they work. The researcher is interested in what the nurses are doing and what they are saying during their work with older people. You are being asked to assent to allowing the researcher to include your interactions with your nurses in this study.
Study Procedures:
If you agree, the researcher’s observations of your nurses’ interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, what you say and do in response.

Potential Risks:
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse. Those observations and conversations will be held in strict confidence.

Potential Benefits:
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

Confidentiality:
The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

Contact for information about the study:
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [redacted] or via email at [redacted].

Contact for concerns about the rights of research subjects:
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at [redacted] or if long distance e-mail to [redacted].

Assent:
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to you as a patient. If you wish to withdraw from the study at any point your data will be removed from the study.
Nursing older adults: Making meaning of complex practice
Assent Form for Patients

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators:
Sherry Dahlke
PhD candidate
University of British Columbia School of Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

Marcia Carr
Clinical Nurse Specialists- Acute Geriatrics, Geropsychiatry
Fraser Health- Burnaby Hospital

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

You are being invited to take part in this research study because you are a hospitalized older adult. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts. If you do decide to take part in this study, you are still free to withdraw at any time and without giving
any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will you lose the medical care to which you are entitled or are presently receiving. Please take the time to read the following information carefully and discuss it with your family, friends, and doctor before you decide.

**Purpose:**
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. This means that a researcher may be observing some of the nurses who are caring for you while they work. The researcher is interested in what the nurses are doing and what they are saying during their work with older people. You are being asked to assent to allowing the researcher to include your interactions with your nurses in this study.

**Study Procedures:**
If you agree, the researcher's observations of your nurses' interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, what you say and do in response.

**Potential Risks:**
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse. Those observations and conversations will be held in strict confidence.

**Potential Benefits:**
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

**Confidentiality:**
Your confidentiality will be respected. You will be assigned a unique study number. Only this will be used on any research-related information, including medical records, personal data and research data, collected about you during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. The findings of this study that has any identifying information removed will be shared in professional and scholarly journals and presentations.

Information that directly discloses your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.

No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records and medical records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives of the FH Research Ethics Board for the purpose of monitoring the research. These personnel are required to keep your identity and personal information confidential. However, no records, which identify you by name, will be allowed to leave the Investigators' offices.
The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection for five years after which time they will be destroyed.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [redacted] or via email at [redacted].

**Contact for concerns about the rights of research subjects:**
If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact either Dr. Marc Folkes or Dr. Allan Belzberg, REB co-Chairs by calling [redacted]. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. If you have any concerns about your treatment or rights as a research subject, you may also contact the Research Subject Information Line in the UBC Office of Research Services at [redacted] or if long distance e-mail to [redacted].

**Assent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to you as a patient. If you wish to withdraw from the study at any point your data will be removed from the study.
Nursing older adults: Making meaning of complex practice
Consent Form for Family Members

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators: Sherry Dahlke
PhD candidate
University of British Columbia School Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

Purpose:
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because your family member is a patient on a unit where this study is taking place. This means that a researcher may be observing some of the nurses as they are caring for your family member. The researcher is interested in what the nurses are doing and saying during their work with older people.
Nurses’ work can also include spending time with and/or talking to family members who are visiting their family member in the hospital.

**Study Procedures:**
If you agree, the researcher’s observations of the nurses’ interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, and what you say and do in response.

**Potential Risks:**
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse and your family member. Those observations and conversations will be held in strict confidence.

**Potential Benefits:**
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

**Confidentiality:**
The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you and your family members will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [contact information] or via email at [contact information].

**Contact for concerns about the rights of research subjects:**
If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at [contact information] or if long distance e-mail to [contact information].

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy you or your family member. If you wish to withdraw from the study at any point your data will be removed from the study.
Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

________________________________________________________________________
Subject Signature Date

________________________________________________________________________
Printed Name
Nursing older adults: Making meaning of complex practice
Consent Form for Family Members

Principal Investigator: Dr. Alison Phinney
Associate Professor
University of British Columbia School of Nursing

Co-Investigators:
Sherry Dahlke
PhD candidate
University of British Columbia School of Nursing

Dr. Wendy Hall
Professor
University of British Columbia School of Nursing

Dr. Paddy Rodney
Associate Professor
University of British Columbia School of Nursing

Dr. Jennifer Baumbusch
Assistant Professor
University of British Columbia School of Nursing

Marcia Carr
Clinical Nurse Specialists- Acute Geriatrics, Geropsychiatry
Fraser Health- Burnaby Hospital

This research is to fulfill the requirements of Sherry Dahlke’s PhD thesis. The findings of this research will be shared in conferences and journals for clinical and research application. A summary of the findings will also be shared with participants in this study.

You are being invited to take part in this research study because you are a family member of hospitalized older adult. Your participation is entirely voluntary, so it is up to you to decide whether or not to take part in this study. Before you decide, it is important for you to understand what the research involves. This consent form will tell you about the study, why the research is being done, what will happen to you during the study and the possible benefits, risks and discomforts. If you wish to participate, you will be asked to sign this form. If you do
decide to take part in this study, you are still free to withdraw at any time and without giving any reasons for your decision. If you do not wish to participate, you do not have to provide any reason for your decision not to participate nor will your older family member lose the medical care to which they are entitled or are presently receiving. Please take the time to read the following information carefully and discuss it with your family, friends, and doctor before you decide.

**Purpose:**
The purpose of this study is to examine how nurses work with hospitalized older adults and the factors that influence this work. You are being asked to sign this consent form because your family member is a patient on a unit where this study is taking place. This means that a researcher may be observing some of the nurses as they are caring for your family member. The researcher is interested in what the nurses are doing and saying during their work with older people. Nurses’ work can also include spending time with and/or talking to family members who are visiting their family member in the hospital.

**Study Procedures:**
If you agree, the researcher’s observations of the nurses’ interactions with you will be included in the study. This means the researcher may take notes about what the nurse is saying or doing, and what you say and do in response.

**Potential Risks:**
Participating in this study entails minimal risk to you. You may experience a loss of privacy by having a researcher observe your interactions with the nurse and your family member. Those observations and conversations will be held in strict confidence.

**Potential Benefits:**
Although there are no immediate benefits, your participation in this study will be contributing to a greater understanding of nursing practice with older adults.

**Confidentiality:**
Your confidentiality will be respected. You will be assigned a unique study number. Only this will be used on any research-related information, including medical records, personal data and research data, collected about your during the course of this study, so that your identity [i.e. your name or any other information that could identify you] as a subject in this study will be kept confidential. The findings of this study that has any identifying information removed will be shared in professional and scholarly journals and presentations.

Information that directly discloses your identity will remain only with the Principal Investigator and/or designate. The list that matches your name to the unique identifier that is used on your research-related information will not be released without your knowledge and consent unless required by law or regulation.

No information that discloses your identity will be released or published without your specific consent to the disclosure. However, research records and medical records identifying you may be inspected in the presence of the Investigator or his or her designate by representatives...
of the FH Research Ethics Board for the purpose of monitoring the research. These personnel are required to keep your identity and personal information confidential. However, no records, which identify you by name, will be allowed to leave the Investigators’ offices.

The identity of all participants will be kept strictly confidential. You will be identified in the researcher’s notes by a different (made-up) name and any information that could identify you and your family members will be changed. All data records will be stored in a locked filing cabinet at a secure location and on a computer with password protection, for five years after which time they will be destroyed.

**Contact for information about the study:**
If you have any questions or desire further information with respect to this study, you may contact Sherry Dahlke at [redacted] or via email at [redacted].

**Contact for concerns about the rights of research subjects:**
If you have any concerns or complaints about your rights as a research subject and/or your experiences while participating in this study, contact wither Dr. Marc Folkes or Dr. Allan Belzberg, REB co-Chairs by calling [redacted]. You may discuss these rights with one of the co-chairmen of the Fraser Health REB. If you have any concerns about your treatment or rights as a research subject, you may also contact the Research Subject Information Line in the UBC Office of Research Services at [redacted] or if long distance e-mail to [redacted].

**Consent:**
Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy you or your family member. If you wish to withdraw from the study at any point your data will be removed from the study. By signing this form, you do not give up any of your legal rights and you do not release the study investigator or other participating institutions from their legal and professional duties.

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

Your signature indicates that you consent to participate in this study.

____________________________________________________
Subject Signature     Date

____________________________________________________
Printed Name

Witness (Principal investigator/designate)
Appendix K: Observation Guide

1) What is the physical appearance of the environment?
   a. Are there physical accommodations for an older population?
   b. Are there barriers for an older population?

2) Appearance of the nurses and other health care providers?
   a. How are they dressed?
   b. Are they mostly smiling, frowning, moving fast, or sitting down?

3) Actions of the older adults
   a. Are older adults calling out?
   b. Are older adults moving freely about the nursing unit?
   c. Are the older adults quiet and in their beds?

4) Actions of nurses and other health care providers
   a. What types of activities do nurses engage in with older patients?
   b. What types of activities are nurses delegating to other health care professionals and why?

5) Interactions between nurses and older adults
   a. Are nurses smiling as they talk to older adults? Are they talking quickly or slowly? Are they making eye contact?
   b. What type of language (ie medical jargon, or baby talk) is used in the interactions with older adults?

6) Interactions between nurses and other health care providers
   a. What type of language is used to refer to older adults?
b. What are the objects and symbols that are used in relation to care of older adults?

7) Interactions between nurses and nurses
   
a. What type of language is used?
   
b. How do nurses let other nurses know about the way to practice with older adults on their unit?

8) Interaction between nurses and managers
   
a. What type of language is used?
   
b. What are the objects and symbols that are used in relation to care of older adults?

9) How are the symbols used in caring for older adults?
Appendix L: Interview Guide

The following questions will assist the researcher to identify demographic information about participants. The information will be kept confidential and anonymous.

1) Please indicate your age.

2) Is English your first language? If not which language is your mother tongue?

3) Can you tell me about your education background?

4) What is your cultural heritage?

5) How many years have you worked in your current job?, at your current institution?

6) Can you tell me about your nursing experience with older adults?

7) Can you tell me about your nursing education with older adults? Do you hold gerontological certification?

8) What do you think is important for me to know about nursing practice with hospitalized older adults?
   a. Why is that important?

9) Can you tell me about how you care for hospitalized older adults?
   a. Is this a usual experience?

10) How do you know how to practice with older adults?
    a. What guides or assists in knowing how to approach practice with older adults?
    b. Are there different ways of approaching practice with hospitalized older adults compared with younger people?
    c. Why do you think that is?
11) Can you tell me about an experience you have had in your practice with hospitalized older adults when the processes seemed to go smoothly?
   a. What contributed to the success of this experience?
   b. Why?
   c. What made you think the experience was a success?
   d. Why?

12) Can you tell me about an experience you have had in your practice with hospitalized older adults when the processes were challenging, or perhaps even negative to you or your patients?
   a. What contributed to the challenges of this experience?
   b. Why?
   c. What made you view the experience as challenging, or negative?
   d. Why?

13) If you had a magic wand and could create the perfect situation for your practice with older adults, what would it look like?
   a. Why?
   b. Why do you think it doesn’t look like that now?

14) Are there any questions you wish I had asked that I didn’t?

15) Any last words?
Appendix M: Field Notes

November 29th, 2010

I arrive on the unit 10 minutes early and find the RN asking the night nurses which assignment she should chose. I learn later that the RNs chose their own assignments. At one time the PCC chose them for them but they didn't like that because she was changing their assignment every day, so they didn’t have continuity with their patients. The assignments are geographic in that all the patients are in the same room or in adjacent room. I talked to a night nurse who explained she has been nurse for 6 months and graduated from university in another city. She has worked on the ... unit and I asked her what the differences were between and medical (she gave me permission to write down her insights) and she said that on the you have one more patient but you have care aides to help with the washes and the charting is different. She said the manager may say it is different but it really isn't on the floor. The focus on fall risk and they use hip protectors and non skid socks. I asked about restraint and she said that they do when they have to but the patients are more confused and not as acute as the medical unit. She said that she thought the model in this other city with the team was better. She said that there the geriatricians and the interdisciplinary team which included a nurse would make rounds and address all of the issue related to older adults throughout the building. She said she thought that things fell through the cracks here because Geriatricians were rarely called.

The night nurse is giving the RN a verbal report. We learn that one of the patients is possibly going to the OR for a TURP. The RN asks the night nurse if she got the consent or started the OR checklist when she learns that she didn't she asks her to please put them on the chart. I note that she has written on her cheat sheet her 4 patients names the Vs, diet, activity, LBM and Foley for them. I check the census and only 2 patients in 21 are under the age of 65.

Except for one other Caucasian nurse I am the only white person including many students and nurses. The other white nurse appears to be the PCC because she is directing the nurses to begin report. As the nurses start to read out the information about their patients she is rolling her eyes and asking them questions like where was that person from, what is the Mews etc? Her tone implies that the nurses should know this information. When they don't they are directed to find that out this morning. One patient has not had a vancomycin level drawn because the patient refused a peripheral draw when they have a PICC line. It appears that the IV therapy team draws from the PICC lines and sometimes they require an order to do that. I hear that one patient has a VAC dressing. The PCC fills in information about discharges, how people walk and explain that the report sheets were started because the Kardexs were not kept up to date. In report nurses use language such as confused. I do not hear about delirium or dementia. One patient
is 100 years old. He is Punjabi and the nurse I am with says it is unlikely he is 100. They may have just told immigration that. They are talking about fall risk, restraints and bed alarms. I hear that one patient was up in the chair for most of the night.

After report the nurse tells me that the first thing she does is go and check to make sure no one has fallen. She checks her patients and explains she is their nurse. It appears that all 4 of her patients are not competent to consent so I obtain their assent to be there. She sets up the tray for two of her patients. One of her patients is being cared for by a student nurse. There are lots of people around, LPN students, RNs students and the nurses. The nurse checks in with the student and learns that the student can not give injections so the nurse asks her to remind her.

The nurse tells me that the PCC rolls her eyes at everyone. She knows she has a stressful job but she is not nice to people and she is not approachable. If you go to her with a question she would say something like you should know that. And if you ask for workload she doesn't seem to believe that it is needed. The nurse describes her as rude and that there really isn't any excuse for the way she talks to people. The nurse also talks about the budget.

With all of the students it is hard to get to the med cart and to get a NIBP machine. The nurse grabs the medication cassette for the student’s patient and the MAR and explains that there is a PRN Captopril for the BP. She asks the student what the BP was and what the BS was. Apparently the night nurses do the am BS. The student seems a bit flustered. There is a patient on a stretcher in front of the desk waiting for a porter to take her for a test.

Finally a NIBP machine is available and so the nurse takes it and the medications for her isolation patients and we go in to give him that. I learn that she often tries to do things together when someone is on isolation to save time. This is the man who speaks only Punjabi. She calls him uncle and she explains that in this culture this is the appropriate way to talk to an older patient. It would be rude to call him something else. Even though she was born in Canada she said her mom made her go to Punjabi classes.

The nurse tells me that she tries to get VS, meds and some charting done by 9 am. So that she is ready in case of a call or something goes wrong. Then she can handle it. She has already been called to the phone to learn that the patient who was NPO is going to go to the OR for a TURP later today. She has IV orders. She tells me that the patient will come back here even though it is a medical unit. This is because there are often no surgical beds. So this is an added thing to their workload.

As she is drawing up her pills she tells me that she often feels like a pill pusher. This is because the patients say no and so she tries to reason with them or she comes back later. This is because they are often older and confused.
She goes into a room and sets up breakfast for another patient. She asks him orientating questions. She calls the man sir. She tells me she is not sure if she should give the medications for the man who is fasting. She says she will ask the other nurses. She likes that she can consult with other nurses. I learn she would never feel comfortable approaching the manager. She is working on this unit because the nurses are very welcoming and they weren't judgmental when she asked questions as a UGN and a new nurse. She has been working here for 3 years and is enrolled in the masters program. She thinks she might want to get into education eventually.

She tells me more about the manager how she used to be the "queen bee" when they had a four bed overflow unit here. Apparently this unit used to be a 16 bed unit and four of the beds were a separate overflow from emergency unit. The nurses would control her patients and would say what she wanted but she didn't really mix with the other nurses. She said now they don't have overflow units they just have overflow all over the building.

She tells me that she likes to do as much as she can so that other nurses don't have to pick up after her. She explains that it took about a year of working before she felt confident enough to look at the bigger picture of the unit. She tells me that the RN/LPN skill mix is a constant issue here. I ask what is the difference between [BLANK] and here because they all seem old here. She explains that the unit has black and white criteria and they pick and choose patients from Emergency based on those criteria.

She goes to problem solve the LPNs IV and to start the IV on the man who is waiting for the OR. We are called by the LPN that the Punjabi patient has pooped all over the floor. The nurse tells me that usually when someone calls you they have started to help clean it up. She is apologizing to me about the PCC and the poopy mess. I tell her not to apologize that I want to see the reality of nursing. While she is taking the patient in to the shower, I get linen for the bed and start to make the bed for her. While we are there the buddy nurse comes to see if she can go for coffee. The nurse explains that the buddy nurse should go for coffee while she is busy.

At 09:15 she is charting. She has given all her meds and has started her IV and has done the vital signs. She is getting non skid socks for the man who had gotten out of bed. She tells me that things are very rushed in the morning. I am explaining that I am looking at things that influence nurses’ work and she tells workload and the increased acuity, the dynamics of the scopes of practices, leadership, and the moral of the unit.

Next she is giving report to her buddy nurse about her patients so we can go for coffee. I have spent a few minutes typing and during that time she has showered another of her patients. She tells me, now I think I can handle things.
As we are walking to coffee she tells me that more and more is being expected of nurses. We are supposed to be physios and OTs all while the work is so heavy. While we are in the report room the PT comes and wants her to translate for one of her patients. She says I am on a break I will come in about 20 mins.

While I am typing this she is going to give her 10 am meds. When I catch up with her I learn that she washed her last patient who is waiting for the OR. She tells me that she always sets goals for herself and often it is to try and get her patients washed by 11 am. She really tries to be organized to try to think ahead of what needs to be done. This is so that she can control her workload in an environment that can often be chaotic. Otherwise she could start to feel overwhelmed especially if something comes up like a patient suddenly crashes or a patient comes back from the OR. Now if a patient comes back from the OR she can ignore her other patients for a while to concentrate on that patient. Also important to help out as much as she can so that when she needs help she will also receive help. She said the staff that is on today is so nice and helpful that you want to help them because you know that they will just go ahead and help you without being asked.

By staying organized she doesn't get behind. I ask what getting behind is like. She says if she gives her 8 meds at 10 then her washes will be late and then it will throw everything off. She won't be on top of orders. She explains that she tells students and new nurses it is important to get to the orders as quickly as you can. If a patient has blood work that the doctor needs to see try and show him while he is up. So if the patient needs new medication it can be started sooner. If she feels very overwhelmed, she feels like crying. If she is on top of everything then if a patient becomes very acute she can drop everything and focus on that and then pick up the pieces later.

I see her asking the PCC something about her patient that is going to the OR. I ask her what that is. She explains that the pre-op checklist mentioned the need for an EKG and the patient doesn't have a recent one on his chart. Apparently the PCC said that it only needs to be done if it is ordered. I help her get her patient who is waiting for the OR up in the chair. She poseys him in and explains that he has fallen so many times so that this is necessary.

I ask her what having your work done means. She explains that it is the physical care and getting people up in the chair. She looks for non skid socks for her gentleman who speaks Punjabi. She couldn't find any on the unit and has gone and looked at the sister unit as well. She says she will tell the OT that the patient needs nonskid socks. While we are in with this patient the patient's daughter comes in and the nurse asks her if the patient is hard of hearing. We learn that he doesn't like to wear his hearing aides. She asks the daughter if he has pain, and if he seems confused to her. She also asks if they get help with him at home because we learn that he lives with her and her husband. The nurse asks the
daughter to bring in the patient's non skid slippers. The nurse asks the OT to give a few words of translation for the nurses to use in working with the patient. She explains that due to his hearing she needs it even though she speaks the same language.

We are at the medication cart and she tells me that she tries to be positive to the students. She checks their medications and their charting but tries to do it in a manner that she isn't on top of them. The student in reporting to the nurse explains that although the patient was complaining of pain she didn't know if she could believe him because he is confused. The nurse explains that always believe the patient when they say they are in pain and that the student should give him something for pain. I hear someone else explaining that sometimes when a patient is crawling out of bed and nurses are giving loxapine that when you give them analgesic they settle and sleep the night.

The nurse then goes to the computer to check the computer lab work. She approaches a hospitalist with some blood work on her patient. She explains that having a doctor that is approachable can make a big difference to how a nurse is able to work. She said they had a hospitalist who seemed annoyed if they came to tell her about a patient's changing status. She said I am not making this up if the patient is deteriorating, the patient is deteriorating. While we are sitting there a patient from another side comes and tells her that the other lady in his room is sitting in her own stench. The nurse gets up and finds the nurse responsible. She is very kind to the patient and thanks him for bringing it to her attention.

She tells me that it is important that nurses look up the lab work because the doctor has not always seen the blood work. He may be on another unit or the blood work may be up after he has left and something may be missed.

She tells me that she is always thinking ahead to make sure her patients are taken care of. She tells me that it shouldn't be but often the students are used as workload. Because she has one less patient to bath today. She and the other nurses find out that the other unit (mirror image of this one) has help today. She tells me that is a whole other issue. If they get more help then this side wants more help and on it goes.

Next she is talking to the daughter of another patient about what is needed to go home. We learn that he lives with his daughter and that he has to be able to do a few stairs to go home. The nurse explains that she will talk to the PT about mobilizing him and about what is necessary for him to go home.

We go for lunch and we talk. Right now I am really thinking about what she said about how there are lots of positive strokes for nurses to be efficient. This is a general statement with in the system. And there is evidence of trying to save money. Replacing RNs when they can with a LPN. And not being encouraged to ask for help. She said you can miss things if you are too efficient. I must think
about that some more.....

After lunch we help position her buddy nurse's patient and then her buddy nurse goes on break. She goes in to check her patient and she thinks he looks off. So she checks his BP and O2 sat and asks him to sit up. I bring a warm blanket for him.

It is now 13:30 and she is updating the Kardex and checking her report sheets. The call bell for another patient of the nurse calls SOB. She checks her O2 sat and gives her some prn nebulizers. She tells me that the most common diagnosis on admission here is pneumonia or related to bowel issues.

When I catch up with her to talk about her comments about how nurses are encouraged to be efficient she talks about how RNs are being replaced sometimes by LPNs and that is all about saving money and lowering costs not about what is best for patients. She talked about how important it is to take time with older adults or you miss assessments. She talked about the pervious leader they had had and how that improved moral. This leader was inspiring, approachable, had an open door policy, came to the unit listened and engaged with the nurses and tried to make it better. He got a staff room for them a d a PCA for nights. Before him there were nurses on the d side that would call in sick for there shift and the. Come in on overtime. There were some nurses who would only come in if there were care. Aides to do the washes, there were med errors. She talked about how she knows from nurses at other hospitals that it is very common to have aides to do most of the care.
August 11, 2010

At the beginning of the shift a younger nurse (bystander permission) has changed the assignment of one of RN 5s patients on the white board. RN5 explains to her that she shouldn’t do that on the board, she should first check with the charge nurse. The bystander nurse explains that she was on for the last two days and had one of RN5’s patients and although it is a heavy load she would prefer to keep her patients rather than learn about a new patient. RN5 explains that in future at the end of the day to tell the charge nurse that she is fine with the workload and explain that she is coming back the next day so please keep it the same. Otherwise another nurse will come on and say why did give me such a heavy workload.

RN5 is checking her Kardex and she gets the charts of one of her patient’s to check the orders because the patient is receiving blood. She learns that the patient (Bessie- consent from previous day) gets Lasix after the blood and that she may be going home to the nursing home after the blood today. One of her other patients (Jane- consent obtained) is ready for discharge back to her nursing home but there is Norwalk in the home and so her discharge is on hold.

RN4 is also on and she asks RN5 about an alert on the charge. RN5 explains that Z alert means many alerts. Other nurses are listening to what she says. It appears as if she is knowledgeable about the unit. There is a new graduate nurse orientating with RN4.

As we are looking through the Kardex, we note that one of the patients (Jessie- consent given) is ordered BM daily by the doctor. The RN and I giggle about how can you order someone to poop.

One of the senior nurses says are we ready? She calls to the PCAs and the PCC to come for report. LPN1 starts and as she is going through her patients she says that one of them is for placement but I don’t know why. The senior bystander nurse explains that it is for psychiatric reasons and that the patient is committed. The LPN talks about hard that would be to be 61 and sent to a nursing home for the rest of your life. The bystander nurse explains that she will be hard to place because of her being committed. Nursing homes only want to take a few of these types of patients.

RN4 when talking about her patients, she explains that one of her patients is dying with a respiratory rate of 4 and that the patient is a nurse pronounce patient. She also says that the family is okay with the patient dying. When questioned about the family, she explains, “you never know about families.”

Through everyone’s report RN5 is writing information on the census. She is writing things like the code status, whether they are discharged or on high flow O2.
As we start to go in to assess her patients RN5 tells me that she thinks it is great that I am following so many different types of nurses. She says you will find that the older nurses are different from the younger nurses. When I ask her how she explains that when she worked at the University hospital on an [redacted] unit, the older nurses would have all of the patients washed and in their chairs and not worry about assessing the patients. The younger nurses would be doing their assessments first and so their patients would not be up at the same time.

As she goes in and checks on her patients she says, “good morning, my name is RN5 and I will be your nurse today.” She also asks them how their night was. The first patient Bessie’s is still receiving blood. She pumps up the cuff around the blood and explains that it takes longer to administer blood because of the PIC line. She explains that sometimes it is difficult to get the blood through in 4 hours when they have a PIC line and that is why she uses a pressure cuff. She then checks briefly on her other patients and grabs a NIBP machine. She remarks that there are two of them standing there waiting for her and that almost never happens. She says that usually it is hard to find a pump.

We go back to Bessie’s room and she takes her vital signs. There are pictures on the windowsill of Bessie when she was younger. The nurses say that a lot of these older patients’ have a history if you talk to them. She says, “One patient told me she used to swim in the ocean when she was a young girl. They may be old but they have had a life. They may have been independent before they came in here but now they are sick and they are dumb.” She is asking Bessie if it is okay that she moves up the blind. She tells me that if they are really sleepy she leaves them. “I check and see what their vital signs were last night and then I let them sleep and do their vital signs at 10 am.” Bessie is sleepy so sometimes I will check the MAR to see if they were given some medication last night and that is why they are sleepy. She notes her O2 sat is 98% on 2 liters. The order was to wean the O2 and to keep the O2 over 92% so I will lower the O2 to 1 liter. She goes to get mouth swabs and then cleans out Bessie’s mouth very gently. I assist her to tip Bessie from side to side so that she can listen to her chest. She removes a dressing that was on her back. She explains, “I always remove dressings the first day because I want to see what is under there. I will put a fresh dressing on.” As she removes this dressing she says it looks like she had a chest tube at one time. She doesn’t need these dressings anymore.

Next we go to the lady in the next bed, Jessie. She is hard of hearing and the nurse helps her to the BR with the walker that is at the bedside. The nurse says to me, “I will check to see if I need a specimen.” She is looking on her cheat sheet.

Next we go to see Joan (consent given). Joan is in a private room and on isolation. Joan’s explains that she has an upset stomach. She is smiling at the nurse and asking if she can have a shower in the BR. The nurse says, “I will bring you towels and a clean gown and then you can go. But call me when you want to go because I will put something over your saline lock to protect it in the shower.” She asks permission to open the window blind. The patient remarks about the great view. As she is
assessing the patient, listening to her chest and checking her ankles the nurse remarks that one ankle is slightly swollen. Joan explains that she had arterial surgery on that side and has had swelling since. The nurse explains that she needs a specimen and so will come back and collect the one that Joan has left in her bathroom.

Next we peak into Mabel’s room (consent given). Mabel has a caregiver in with her giving care so RN5 says she will come back later. She tells me that she has been a nurse for 17 years. She has latex sensitivity so she wears certain gloves. We note that she has 4 patients. She says likely it is because it is heavy or maybe because there are 3 over census patients and so there is an extra nurse.

We go back to see Jessie who has returned from the BR. Jessie explains that she is cold and wants a dressing gown. I get one for her. The nurse is doing her vitals signs and assessment and talking to her about needing a specimen. She explains that she will leave a container in the BR and asks her to call when she goes so she can get the specimen. She helps Jessie to settle in a chair looking out the window with the call bell within easy reach. She has gotten her water but Jessie’s says it is too cold. The nurse explains to me that often-older patients prefer water that isn’t too cold. I go and get more water from the kitchen. The nurse dispenses Jessie’s medication and stands there while Jessie takes them one by one. As she is taking her pills she says I will take the important ones first, the levadopa. The nurse asks if Jessie would like her to cut the big ones like the calcium in half. Jessie takes them and says I am tired I would like to lie down. The nurse says, “Does that mean you want breakfast in bed.” Jessie says, “No I will sit up until after breakfast.” The nurse asks if she is SOB. Jessie’s said, “not now but I was last night.” We also learn she had a BM last night. The nurse asks if she is dizzy and Jessie replies that she is not dizzy but has a headache. She asks her if she has trouble with constipation at home. Jessie explains that she does and that is why she is on a laxative.

The nurse explains that some people can take all their pills at once. Some people take them one by one. She explains that often the workday goes by fast. She explains that working with older people they need more help, with their care and taking their medications. If you work on acute medicine it is fast. People just take their medications and they can help themselves. She is writing her vital signs on the door charts as she is talking to me. She explains that if the blood pressure is unusual she will write it on her sheet as well so that if the doctor asks her she has it on her.

The nurse goes to the BR. Before we go she explains that often she has to go but then she remembers something about a patient’s need and she does that first. We talk about how nurses often put patients’ needs before their own. I notice that she appears to be scanning the environment every time she comes in the room. I ask her about this and she confirms that yes, she is checking to throw out old food and make sure the things she needs are there. And that patients can reach call bells. One of the bystander nurses says to her, “you were quite assertive there.” She explains in the morning with the young nurse that was changing her workload. The nurse
says when they are new you have to tell them these things or they will do whatever they want and then there will be a problem.

Next she goes to the Kardex and obtains the specimen requisition for one of her patients. She goes in and collects Joan’s specimen. She tells me I can’t send the Cdiff because the stool is not loose enough. Joan is given towels, gowns, and a disposable pull-ups for her shower later.

We learn that there is an extra nurse today because the load is heavy not because there are over census patients. The bystander nurse asks, “Do you want to go for coffee?” The nurse asks, “Haven’t given my medication yet so can I go second.” The bystander nurse is an inexperienced nurse she shrugs her shoulders. She asks me, “Are you hoping to see a fight?” I said well do you want me to see a fight. She says, “no we love each other here. We work together.” She explains that as an experienced nurse she has learned to go with the flow. “This is a heavy floor and some nurses get sick for the heavy lifting and you can get hit. I have been hit before. You have to do what you can to make it easy for yourself.”

Next the nurse goes in to see Mabel and does her assessment and gives her pills. She explains to me that she is going to leave the pills because there is a caregiver there to help her. Sometimes people don’t want you to watch them taking their medications and so you just go back to see that they have been taken.

While I have been here typing these notes, the OT and PT have explained to me that one of the patients on the unit has been ordered a transfer to TCU. TCU is a different type of unit from SAM because it is more activation and patients have to be more stable. Patients go home from TCU not to a nursing home. But the health authority has recently decided to charge patients 30 dollars a day to go to TCU so older patients are refusing to go. They may not be able to afford it.

I have also heard LPN1 ask RN3 if she needed help. They have chatted about working with a patient. Then RN5 has come by because a transport has come for her patient receiving blood. This is something that was not communicated to her in report, so she was not prepared for it.

When I catch up to the nurse she explains that communication in the Kardex is very important. That this transport coming was not indicated in the Kardex. If she had known she would have focused on getting this patient ready for discharge. There was an order for a probable discharge, not a for sure discharge and there was no indication about the patient having a PICC line and whether the nursing home would be expecting the patient to have a PICC line. The nurse explained that she talked to the CML telling her that none of this was written in the Kardex to communicate to her. She called the doctor and a resident was going to come up and assess the patient and write the discharge order. She discontinued the PICC line as he had received an order to do so and checked if the doctor wanted a CBC post transfusion. She said she asked the PCC to do the transfer sheet. She tells me that she and the
PCC washed the patient. Then she went and talked to the doctor (resident has given a consent form). She asked the doctor to talk to the daughter who was there to accompany her mother. The nurse explained that the daughter wanted to ask the doctor about the chest X-ray. The doctor asked the nurse why the RT didn’t come and reassess the patient last night as she had ordered. The nurse asked, “Do you want me to call the RT stat? I have had the patient off 02 for 1 hour and her 02 sats are 96%.” The doctors says let me just talk with my team. The doctor goes in to talk to a senior doctor and explains the situation. The nurse talks to the PCC about the challenges she faced this morning because there was no definite order for a discharge and nothing was communicated about the PICC line or that the transport had been booked. She said, “This is my first day. I come and I don’t know what is happening.” Then she goes in to talk to the daughter and explains that the resident will come in and talk to her and that her mom is ready to go if the transport comes.

Next she reports to the bystander nurse about her patients. She explains that Bessie is ready to go. And that Mabel has a caregiver. She says, “I am just going to saline lock Jane’s IV.” The bystander nurse says, “I will do that you go.”

We go for break and she talks about how important it is whom you work with especially when you are on nights. She explains that there is only three of you and the PCAs so you really need to work together. She said if people pull their load then the work is easier. She said on nights when you get an admission, one nurse does the vitals; one starts on the chart so that the other nurse can do the assessment. She said last week on nights when she went to do the admissions, there were no charts made up and there were no paper in the printer in order to print MARs. She said after the second night she talked to the PCC and still nothing happened and so she emailed the manager. She said, “when I am tired at the end of the day it is because I have had to run to the other unit for supplies that are not stocked or run for water because the patient doesn’t have water.” She said it is all the time that they are running for equipment that has not been stocked. She said that she has also been charge nurse so she knows that it is busy on other units as well. She knows that nurses are being pressured on other units to accept more admissions as well. She said that on nights there used to be a float nurse to help the whole hospital but where they went was prioritized. The elderly were the last priority for getting help. I asked if this was a reflection of society and she said yes. She said sometimes we get a float nurse who has never been here and they can’t believe how heavy it is here. They think that everyone is no code and all you do is give pills like a nursing home. She said they think they are no code because they are old. She says I tell them in ER most of the people are 60 and older. If they are older they will stay longer especially if they need placement. She had worked for a while in the states and everything was fast. If a doctor ordered to a nursing home they went that day. If the doctor ordered a chest X-ray as soon as I turned around there was a porter coming to take the person to X-ray. But people paid for everything so if you used one gauze the patient had to pay for that.
She told me a little bit about when she worked at the university hospital how there were some older patients and some younger patients. She said it wasn’t as good. She said when it is an [redacted] unit the nurses’ switch they’re thinking to slow down. We need to take our time, assist them, walk them to the BR, and take time giving medications. It is a specialty. The younger patients are more demanding. They ask more and so you spend more time with them. And the elderly are harder to take care of. When you saw that you were getting an older patient you would say AHH because it slows you down, they are heavy. Nurses are overwhelmed. She explained that the younger patients get a lot more aggressive treatment than the older patients unless they have family who are advocating for them. Some float nurses think that just because they are old they should be no code. But they may not want that.

She said I love bedside nursing and this is where I want to stay. It is hard but at the end of the day I like to know I did a good job. I think it is important for us to tell each other that we appreciate the work we do. It would be nice if the manager talked about the good we do as well as what is going wrong. She talked about how their manager is soft and not so involved. She is nice to talk to but she is not proactive about things.

She said attitude is a big problem in both young and old nurses. The young nurses may think they have learned it this way in school and the older nurses may say this is just the way it is. You need flexibility and common sense. I find the younger nurses don’t always have the common sense because they don’t have the experience so they are going by the book. Flexibility and helping each other is very important. She talked a little bit more about how she had to talk to the young nurse this morning about changing the assignment so she wouldn’t just go and do that all the time. The PCC also didn’t communicate with her last night that the nurse was coming back and wanted the same workload. She could have said I am going to change your workload tomorrow to the nurse yesterday.

When we return to the unit, the CNS is consulting with one of the nurses and the PCAs about one of the patients. I talked to LPN1 and asked about the day I worked with her. I said that I noticed she baths most of her patients is that usual for her because I have noticed that not every nurse does that. She said that was usual for her so that she can see all of their skin.

I talked to the older bystander nurse about what she said about making it easy for herself and asked her what she meant. She explained how as a nurse you have to multitask always know what is going on at all times. She said it is heavy here with difficult patients. Younger patients are more alert, independent and demanding. She said sometimes families are difficult here. She said one time she had a family afraid if they left their mother would fall. She said I don’t want my patient to fall. If they fall it is more work for me, checking vitals and that sort of thing. I make it easier by watching and preventing.
RN5 is in with Jane and is explaining how she used to live in the west end when she was a teenager and how there was a much nicer beach then. There were colonial homes and a larger beach. She said she loved to live there then. But things changed and they changed quickly.

Then the CML came to apologize to RN5 about the situation of miscommunication regarding Bessie’s discharge this morning. After she left I said is this usual for her to apologize or is this because I am here. RN5 said that when I am in charge I push her a lot because she doesn’t do things. She expects that the nurses will do it. So we have had a few run ins. The RN5 said to the CML, “apology accepted. We all have miscommunication at times. It is really important to communicate in the Kardex.” The PCM had implied that it was a casual nurse working the day before that hadn’t communicated in the Kardex. The RN5 tells me, “I speak my mind.”

While we are in the hallway a patient rolls by on a stretcher. This new patient is for RN5. I ask her if she knew about it. She explains that she didn’t, the PCC didn’t communicate it to her. She said when you are PCC it is important to communicate these things to the nurse so she can get prepared. I said is she learning her job because she is new in this job. The RN5 says no I know her, she is like that.

The patient cannot be settled into bed because there is still the RIC mattress from the last patient. So the patient is in the hallway with her daughter. As it turns out the patient can’t speak English but speaks the same language as the nurse. The nurse checks the patient’s vital signs while she is in the hallway. She explains to the patient that the bed is being cleaned. The daughter is also there to interpret and they both quickly agree to participate in the study. After a few minutes the manager and the LPN1 push a bed down the hall for the patient and then we settle the patient into the room. The nurse tells the patient that she is going to check the orders so not to eat or drink until she tells them. She goes to the chart that the unit clerk is processing and looks at the order. Since there is no order for the IV she says I can saline lock that IV. And she can eat and she is going for a CT scan later. The unit clerk asks RN5 for advice about entering certain blood tests into the computer ordering system. As we walk away I comment to her that it seems that other people ask her opinion about things and how to do things. She explains that I am not afraid to do anything and I look for opportunities to learn how to do things on the computer so that when I am on nights and I get an admission I know how to do things. Some nurses get the unit clerk to do everything and then when they are on nights they don’t know how to process orders.

Next it is time to go for lunch. The older bystander nurse is talking to me about why I am doing research and telling me that broada chairs are important because they allow you to keep the patient safe, give less medications, and you can watch the patient. She says we have approval to use them from the CNS.

RN5 is giving report to the bystander nurse about her patients. She explains that Jessie’s’ urine was cloudy and stinky so she sent a urine for C & S. Then she runs
through her patients explaining that Josie the new admission is waiting for a CT but her daughter is there to interpret. That one of her patients is waiting to go back to the lodge.

After lunch at 14:00 she checks to see if her discharge has left. The patient is gone but the bed has not been cleaned yet. I see the Rehab assistant walking Jessie in the hall.

The bystander nurse asks me if I would like to go a unit party in the future celebrating 10 years of the unit.

14:40 RN5 is sitting down to check charts and she finds that Joan has been ordered a 500cc bolus because they think she is dry. At this time there is a PCA walking around and a young nurse is removing her orange and black nail polish that she had on her fingernails. The RN is called to the phone to talk to Jessie’s family. She sends a Cdif specimen to the lab via the pneumatic tube. The nurse explains that Jane got up for a shower and was incontinent of BM and was very embarrassed. The nurse explains, “I told her that it is okay. It happens.”

Next she goes into Jessie’s room and tells her that her nephew called and “I said you were doing great so you better behave now when he comes in.” Jessie smiles and laughs. She said, “I told him you were grumpy this morning and he said that was normal.” Jessie says, “yes that is normal and I feel okay now.” The nurse says are you having an afternoon nap now. Jessie says yes. After we leave the room the nurse tells me that she had scanned her bladder after one of her voids this morning because it was so little she was going but there was no residual urine.

It is now 15:15 and the RN has gone into Jane’s room to hang the bolus and discovered that the saline lock wasn’t working so she restarts the IV and then hangs the 500cc bolus. While she is starting the IV Joan is talking about how her husband died about a year ago from prostate cancer with bone mets. During the IV start she is smiling and joking with the nurse. We go back to the desk where the nurse is charting.

She says there are cookies on the unit and so I need coffee. As we go down to the cafeteria to get coffee she explains that today is actually a quiet day but then you never know what is going to happen. I will get another admission. Usually at 30 minutes before my shift ends I go to my patients and tell them I am going home in 30 minutes, can I help you to the bathroom or get you anything. Or I tell them to behave for 30 mins. They usually laugh at that. Because sometimes a patient might fall 2 minutes before 7 and then you have to stay and help your patient.

15:30 a resident is talking to the nurse about Jessie and how much she is voiding. The nurse explains that she is incontinent and she is only voiding small amounts frequently. The doctor explains that they are going to stop a medication that was for incontinence and that sometimes causes retention.
The PCC comes by tells the nurse that she will be getting an admission, a patient who is coming in with delirium. The nurse also tells the PCC about the acuity level of her other patients.

The older bystander nurse talks to me about attitudes. She explains that if I think I am going to have a bad day, I won't get through the day. So I just do what I can do and focus on what I can do and go with the flow.

We go to Jessie’s room because she called that she had peed. The nurse bladder scans her for 78cc. She asks Jessie to call her if she has to go again. The patient states well maybe next time I will go. The nurse said you did go this time just not very much. As she leaves she makes sure that the patient can reach the call bell.

She talks to Josie who has just returned from a CT. She asks her if she has pain. The nurse relates to me that Josie still has pain in the abdomen. The nurse goes and takes Joan’s vital signs.

The nurse is at the desk in the hub charting and she is talking to the OT about the fact that Jessie is not retaining she is just voiding small amounts and she has sent a specimen. I remark that she has sent a lot of specimens today. She says that if they have a BM you have to send it because they may not go again for three days.

1600 and she is updating the Kardex for all of her patients. As I remark that her admission has a diagnosis of delirium, she says that is a common diagnosis for this unit.

The OT and PT have been sitting at the desk reading charts and chatting with each other for quite some time, perhaps about 2 hours.

16:30 the delirious patient has been admitted. She tells the delirious patient that your daughter will look for you in this room as she directs the patient to her room. The patient is refusing to put on the hospital pajamas. The nurse talks to both the PCA and the PCC and explains that the patient is not combative now but it looks like she could get agitated. The nurse checks the orders and gives the patient some Loxapine. She is unable to find a wander guard bracelet that has been ordered. So she asks one of the nurses to call another unit that also has wander guards to borrow one.

16:45 sending a urine specimen of Josie's to the lab. The lab is phoning to talk to her about a specimen she sent earlier for Jane. She talks to the lab and discovers that the first specimen she sent they were able to use for Cdiff.

1650 The wander guard from the other unit is sent down and the nurse puts it one the patient and patiently redirects the patient back to her room. She has already
told the patient four or five times in the last hours she says your daughter is going to come and find you in this room.

As we go for supper she explains to me that your approach with these types of patients is so important. Don’t fight with them. Give them space and give them the meds.

When we come back the PCA explains that the delirious patient has been pacing back and forth since we have been gone. She is not more agitated. The nurse gives her medications and saline locks one of her other patient’s IV.

Then she sits down to finish her charting and her Kardexs. We talk about the lady who has delirium. She explains that if this patient were on another unit she would be restrained and drugged. She said on a regular medical unit they don’t know how to deal with this type of patient. We are a specialty unit and we know how to approach this type of patient. She says we are not allowed to restrain here...well using broada chairs and sedation is also a type of restraint. The nurse has told me that she used to float all over the building so she has gained a perspective of what it is like on other units.

18:15 Nurse redirects delirious lady and gives Tylenol to another patient.

1820 she does Josie and Jessie’s vital sights. Jessie has a conversation with the nurse about her money that is locked in safekeeping. Jessie is worried that there is more money that she thought. The nurse and her joke about how it is good to worry about having more money than you thought. She tells Jessie, “Your blood pressure is as good as a 20 year old girl.” She explains that she might be going home tomorrow. Jessie jokes, “If I’m going to mis-behave I’d better do it soon.”
Appendix N: Memos

June 10, 2010 Memo

I am becoming more and more aware of the multicultural nature of this unit. The patients are often of a variety of cultural origins and often patients cannot speak English. However, there are also often nurses of multicultural nature who can often speak some of the languages of the patients who can’t speak English. This is fortunate. It also means that nurses have accents and patients have accents. I wonder how usual this is to other settings. This is not usual from my 30 years of nursing experience. Do those language, cultural issue influence nursing practice? Is it different than with younger people? It seems that often if the patient can’t speak English there are many family members present and often they can interpret.

I am wondering about the dominance of physicians in nursing practice. The RN indicated that the doctor was the top and that the role of the nurse was more of an in-between role. Interfacing between the patient and the doctor and family and ensuring those other systems, tests, and other services served the patient. These last two shifts I have been struck by what hard work that is. How the nurse must be so very vigilant and thinking about what should be happening, what should be ordered, and are the systems supporting that. For example, the patient is supposed to be on certain medication and yet it wasn’t supplied so the nurse had to call pharmacy and refax the order. A constant vigilance and advocacy for patients.

I am also becoming aware that much of nursing practice is done behind the scenes ensuring that things happen. The actual interaction with the patient is a smaller part of the entire practice. I wonder if this is a change over the years. Although I have been a nurse for a long time I can’t really answer that question myself. I wonder if this is different in different settings. I would guess not.
What do I mean by ought?

The internalized expectations about the way nurses should conduct themselves and how to deliver care. Delivering care includes how to approach assessing, planning, and implementing the care.

I wonder if the gap also has something to do with the grief about how care used to be delivered and the way it is now. There is definitely a movement towards non-professional labor to deliver more of the bedside care as professional nurses are more involved in technology related to care (omni-cell pharmacy, computers) and orchestrating the people and resources that the patient needs. The trade off of using this cheaper labor is that the professional with the most knowledge is not at the bedside as frequently to assess for those subtle changes in conditions, which can mean much more with an older population. Nurses are grieving this and the personal interactions that they were able to have with their patients. If they are not having these interactions they get less satisfaction of the end users’ responses to their work. They also miss the personal chats of getting to know these patients as people. So they wonder how can they individualize care when they have less opportunity to interact with their patients. Also the individuals who are most involved at the bedside are often out of the communication loop.

If this way of caring for older adults is to persist they need better ways to communicate with the non-professional nurses at the bedside need to be established and maintained. The notion of individualizing care needs to be re-thought. Are there general principles that can be followed? Does the nurse who is directing the care need to spend more time talking to the care aides about how to individualize the care? It seems given that older adults are less homogenous as they age the need for individualizing care because of paramount importance. How can this be forged in acute care settings with very little continuity in staff and such a rapid pace circling around the older adult?
Memo April 22, 2011

After my meeting with Alison I can see that keeping comfortable is more of a purpose or goal of nursing.

So the goals of nurses working with older adult patients and perhaps with all patients are:
  - Keeping safe
  - Progressing through illness and/or hospital system
  - Keeping comfortable

In doing those goals nurses central problem is doing the best for each of the older adult patients.

Nurses are using their knowledge of hospital systems, resources, and people to orchestrate what is the best for each older adult patient based on their assessment of the older adult’s trajectory of illness and the context of the older adults, which includes family, function, co-morbidities, living circumstances.

Orchestrating is the BPSP that nurses are using to bridge the contexts of the acute care hospital and the older adults.

Orchestrating is a highly complex activity in which nurses are multitasking the activities they need to do and/or think about for the best option for each of their older adult patients in an environment where the focus is on acuity and where there are often over-census patients. Thus what is the best for each of the nurse’s patients can change “on a dime” based on the health status of any one of their patients, or the changing circumstances of the unit.

The properties of Orchestrating are compensating, advocating, collaborating, and guarding.

Compensating are the activities the nurse has to orchestrate to allow the needs of the older adult with the hospital systems that are not designed to accommodate chronically ill older patients with multiple co-morbidities and high functional needs. The nurse has to compensate for system deficiencies and for the patient’s disabilities. The older patient has increased functional needs requiring assistance with ADLs, cognitive challenges, and working with family to understand the part of the functional needs that are related to the acute illness and what has been the normal for the older adult. Nurses are compensating for the system when it doesn’t work. They are running for equipment and supplies that are not supplied. They are making extra phone calls to find equipment, people, or information about what happened to the patient in a different unit.

Advocating are the activities the nurses are doing to obtain the right equipment, orders, people for the older adult to achieve the goals. Sometimes they are advocating for the hospital systems, for example the visiting hours or adherence to isolation procedures by visitors who are putting the patient and other patients at risk by not adhering to these
procedures. Sometimes they are advocating the patient who may have a family member that is abusing the older adult. Sometimes they are advocating for proper treatment of staff, i.e. “I am not your whipping post.” Frequently they are advocating for the right type of progression by making the older adult comfort care and stopping interventions that nurses’ viewed as unnecessarily cruel given the patient’s condition and trajectory of illness.

Collaborating are the activities nurses are engaging in with other nurses, with families, with other health care provides and sometimes with agencies out side the hospital to achieve the goals of care. Nurses talked about “who you work with matters.” So being a team player was something that was valued because as nurses worked together they were able to achieve the goals of the patients easier. Sometimes depending on who you were working with your may have to advocate for the individual’s involvement or they may just collaborate. I can think of examples around a physiotherapist and physicians. This is about inter-personal relationships.

Guarding are the activities the nurses are engaged in to keep the older adult safe and to maintain the integrity of their practice and the standards of the unit. Nurses are constantly checking that the patient is breathing, that they can reach their call bell, that they are comfortable, that the right medication has arrived, that the right medication has been ordered, that the doctor saw the lab work and ordered appropriately, that the nurse before them didn’t miss anything. They are checking people, and systems. They are protecting older adults by finding and fixing the errors, by managing falls, wandering, infection, and people at risk from gaining access to the patient. To protect against falls and wandering they use bed alarms, Geri chairs with the person in the hallway, lap belts, wrist restraints, mitts, sedation, or 1-1 sitters. To protect against infection they wash their hands, they use isolation procedures and they monitor the risk of infection of the admissions that come in to the unit. They guard the patient from individuals at risk by making them an unregistered patient, by calling security, etc. They also guard each other’s practice by not bad mouthing other nurses and health care professional and by going through appropriate channels such as managers if issues of concern arise. There was lots of evidence of senior nurses guarding casuals and new nurses by watching them and asking if they needed assistance and offering assistance or jumping in with assistance.
April 18, 2011 Memo: Orchestrating

Orchestrating is a complex BPPS that nurses are using to multitask the activities they need to do and/or think about in order to facilitate the connections of hospital resources with each of the older patients in their care with the purpose of keeping patients safe and facilitating their progress through the hospital system. Nurses are using their knowledge of hospital systems, resources, and people to orchestrate what is needed for each of their older adult patients, based on their assessment of the older adults’ trajectory of illness.

Nurses explained that a great source of frustration for them occurred when part of their brain had to be used for thinking, where can I find this, when they are also orchestrating all of the needs of their patients. In other words their capacity to orchestrate is enhanced when resources are readily available, and when communication systems work. I can think of an example when a patient just arrived and the nurse did not know the patient was coming. This communication glitch (that I’m told does happen) influenced the nurse’s capacity to orchestrate what was needed for that particular patient as well as the rest of the nurse’s patients.

Orchestrating is making the bridges between the context of the hospital and the context of older adults needs.

Orchestrating is extremely important because the nature of focus on acuity in hospital care does not accommodate the functional needs of older adults. For example nurses (LPN3, RN9) talked about how the older adults sometimes get sicker because nurses are not focusing on their functional needs, which will assist older adults in progressing to discharge (such as mobilizing them) because they are focusing on more acute life and death issues with other patients.

Older adults needs are complex because they are a heterogeneous group. In other words as we age we become more unique. This means that although it is more likely that older adults will have chronic co-morbidities, each older adult may have a slightly different combination of co-morbidities and different trajectories in their illnesses. Function is considered a vital sign of an acute illness with older adults. Focusing on maintaining and restoring function is an important part of care of older adults. Simple things like getting out of bed have been known to improve delirium. Another factor related to older adult care is that they are towards the end of their life and so when they are acutely ill, it could be the illness that takes them (death). As a result often there are DNR orders. But DNR does not preclude acute interventions. Also associated with older adults is the presence of family frequently to support the older adult or be proxy for the older adult in decision making about life and death issues and/or acute interventions. Older adult patients may have been living at home independently or they may have come from a nursing home. The current illness may mean that their previous home environment is not suitable any longer. All of these issues are the contexts of older adults and contribute to the complexity of caring for this population.
As a result of the contexts of the older adult population, nurses need to orchestrate resources to investigate and plan for a safe discharge if and when the older adult is able to go home. This means that the nurse could be in conversations with nursing homes that the older adult came from and/or discharge planning nurses. This could also require the interventions of the social worker, the OT, PT, etc., all depending on the needs of the older adult. The nurses are pivotal in this orchestrating because of their moment-by-moment contact with the older adult and often the family, as well as the nurse’s knowledge of illness and assessment of the trajectory of the older adult’s illness.
Nov 12, 2011 Orchestrating

Nurses were orchestrating organizational resources to support them in developing lines of action that took available resources and the immediate needs of their patients into consideration. Orchestrating explained how nurses processed multiple data from numerous sources in order to determine their patients’ needs, their available resources, and then mobilize the resources for their patients’ needs. When nurses were orchestrating they were trying to stretch and manipulate the resources within the hospital context to better meet their internalized expectations of giving good care to older adult patients. The process of orchestrating included doing reconnaissance and coordinating resources.

Doing reconnaissance was a state of action in which nurses assessed the status of their patients, their environment, and their available resources. Nurses were perpetually doing reconnaissance because their patients’ status and the acute care context was ever changing, requiring nurses redefine their possible lines of action on an almost continuous basis. A quick glance at nurses working might have appeared as if nurses were engaging in social conventions by chatting with patients and other nurses; however, the more experienced the nurse, the more assessment, evaluation, and conclusions about priorities were occurring in these social interactions. In a few brief social moments, nurses would scan patients’ color, possible cognitive states, the emergency equipment available, the IV, safety hazards, and which health care professionals (HCP) were available to assist, to name only a few of their observations.

Coordinating is the function nurses employed to match the appropriate resource and/or information with what the nurses saw as a priority for patients and/or the unit. This was evident in the ways that nurses scrambled to find resources or ways around existing processes to meet sometimes the most basic of needs for their older patients. During my participant observations and in my own clinical experiences nurses were constantly looking for equipment such as intravenous (IV) poles, blood pressure machines, and basic tools of the trade such as a basin to wash a patient, a urinal, bedpan, or toilet paper to toilet patients, and even food and water.