

NEGOTIATING THE EDUCATION AND PRACTICE
DISJUNCTURE IN NURSING CLINICAL PLACEMENTS:
NURSING FACULTY'S PERSPECTIVES

by

KATHERINE FUKUYAMA

BSN, The University of British Columbia, 1973

M.Ed., The University of British Columbia, 1987

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Abstract

This qualitative research project is an exploration of how nursing faculty make meaning of their experiences in the disjuncture between what is taught about best practice and what is found in many clinical practice sites. Nursing faculty members teach best practices, but when they take students into practice arenas, the students do not necessarily see those best practices. Instead, they may see caregivers substituting “supposed efficiencies” for best practice. As guests in a hospital, faculty members have no clear-cut entry point to make changes. As both nurses and educators, they face quandaries in places where practice is inadequate; they may want to remove their students but because they are nurses, feel ethically obligated to stay and to attempt to change practice. As educators, they must role model competent nursing care yet may be in a setting where structural conditions create a situation in which nurses are unable to provide best practice. The nursing faculty’s role creates a unique liminal place at the practice-education interface that is challenging and uncomfortable.

Constructivism/interpretivism and critical theory inform this study. The main theorist is Dorothy Smith (1992, 2005, 2006). Smith’s critical theory perspective brings into view power relations that organize, but are often invisible to, the everyday activities of nurse faculty in clinical settings. Twenty-four clinical nurse faculty members from post-secondary institutions were interviewed. The main themes arising from these interviews were conflicts, dual consciousness, being a guest and maintaining placements. Analysis of these themes found that faculty members engage in a complex set of negotiations to address disjunctures as they seek to meet the needs of students, patients and staff. The complexity of the navigation is reflective of how faculty and staff nurses are embedded in a nest of social relations with other caregivers, administrators, patients and their families under conditions of neoliberalism. A

neoliberal corporate ideology that has infused the health care system has made it difficult for nurses to provide care as they are taught. These uncomfortable moments can become teachable moments not only about “good practice” but also about advocacy for change in structural conditions that constrain “good practice.”

Preface

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Chapter 1 Introduction

1.1 Problem & Significance

This qualitative research project is an exploration of how nursing faculty make meaning of their experiences in the disjuncture between what is taught about best practice in nursing and what is found in many clinical practice sites. Nursing faculty members face daily quandaries as they increasingly bear witness or hear from their students about cases of clinical practice that do not meet the standards of care being taught in nursing programs. The contexts on which I focus for this study are situations in which the nursing faculty members are teaching groups of six to eight students in clinical settings in which neither the teachers nor the students are paid staff of the health care organization. Most often in Canada, a clinical experience is an instructor-led experience in which an instructor (who is an employee of an educational institution) takes a small group of nursing students to a clinical setting and teaches them to apply what they have learned in school to real-life patients. The instructor is not part of the staff at the clinical setting. I describe this context as a liminal space within which an inevitable tension arises. By liminal space, I mean a space at the edge where people do not have power or authority.

As a member of nursing faculty in a college, I have a great personal interest in this issue and wanted to explore how other nursing faculty members, through their own accounts, think about and act in relation to these predicaments. Through this research, I aim to contribute to better understanding of this issue, which in turn can contribute to the development of curricular strategies to help faculty and students navigate these disjunctures thoughtfully and act on their responsibilities as advocates for good nursing care.

Increasing the depth of understanding of how nursing faculty are able to navigate in the practice-education disjuncture could help build curriculum that directly addresses the disjunctures so that students can learn strategies to use and to carry on into the workplace as graduates; faculty can consider what role they can play with respect to addressing the structural problems in health care delivery.

I begin with a clarification that inadequate nursing practice is not found universally. In fact, there are numerous sites where care is ethical and competent. Schools of nursing use clinical placements throughout the health care system and nursing faculty come across all kinds of nursing practice. In this paper, reference is made to inadequate practice, but it is not meant to suggest that there are no nurses or other health care professionals who act as exemplary role models for the nursing students. These role models are found across the system and provide nursing faculty confirmation that best practices can prevail.

The following story reveals some of the complexities at the practice-education interface. The historical, political, social and economic issues within the practice and education contexts influence how nursing faculty make choices or decisions.

B., an experienced instructor in a school of nursing, tells a story about a clinical placement where a practice existed of putting naked elderly patients in slings hung from the ceiling lifts over a pad on their bed instead of being placed on a commode or taken to the toilet because, according to the care aide, it took much less time. Horrified by the insensitive treatment, one of B.s' students insisted that she would take the person to the toilet. The care aide became angry and refused to allow this. The student felt powerless and demoralized. B. intervened and helped the student take the elderly person to the toilet. The instructor and students felt that they had a position to take as advocates for

the elderly people in this particular care facility. They wrote a letter to the Director of Care. The response was surprising. They received contradictory and confusing messages. They were told that they had not followed the right channels of communication. They were told that they should have gone to the unit manager with the complaint. The school of nursing was admonished for allowing students and faculty to digress from communication protocol and a large meeting was organized to discuss the collective behaviour of the students and the instructor rather than the unacceptable practice. The administration at the school was annoyed with the instructor because she had jeopardized a clinical placement that took several groups of students and clinical placements were difficult to find. However, at the meeting, both the nursing school administration and the facility administration agreed that putting people in slings was unacceptable nursing practice. Students and instructor were assured that this practice would stop. However, subsequent visits proved that the practice was still continuing because the care aides felt that there was too much to do and the additional time to fetch a commode from the end of the hallway could not be spared. They felt that they were unable to change the unethical practice because of the workload.

This story demonstrates multiple difficulties faced by faculty and by other health workers such as care aides. In this story, critique of poor practice led to critique of the complaint channels used by nursing faculty and loss of clinical placement for students. Yet ethically, nurses cannot witness and, by their silence, condone this distressing practice of “hanging patients.” In this scenario, the faculty member is in conflict with the school of nursing administration and with the clinical facility administration. Another layer within this story is the issue of power. The caregivers in this scenario are care aides, who are at the lowest rung

in the care hierarchy. Care aides have little or no voice in their workload. Could an analysis of power and the health care hierarchy aid the students and nursing faculty in this situation? How could they have worked in collaboration with the care aides to change the situation? How could the students and faculty work with other caregivers as well as patients? The issue of power was also underlying the response by the administration, which seemingly ignored the patient-focused problem and instead focused on the break in the hierarchical procedure of communication or the chain of command.

Nursing faculty members combine two roles of nurse and educator within multiple contexts including various clinical practice sites and educational institutions. Embedded within each context are historical, political, social and economic issues influencing their activities. In the educational setting, faculty teach student nurses the ideal way to care for people but then must bring these same students into the messy reality of practice. Nursing faculty members teach best practices, but when they take students into practice arenas, the students do not necessarily see those best practices. Instead, they may see caregivers providing what they perceive as efficient time saving practices, as in the preceding story. The nurse faculty may point out that this is not the ideal way but because they are guests in the hospital, they have no clear-cut entry point to make changes. As both nurses and educators, they face further dilemmas in places where practice is inadequate; they may want to remove their students from such a place but as nurses, feel ethically obligated to stay and to attempt to change practice. As educators they must role model competent nursing care, yet they may be in a setting where structural conditions create a situation in which nurses are challenged to provide best practice. Faculty are in a liminal state, meaning that they are lacking status in the practice field, because they are not employees of the clinical agency yet must navigate

and negotiate as if they were part of that culture. They are in a unique location with respect to the practice-education interface — a liminal place that is challenging and uncomfortable. Students need to be educated about the disjuncture. These uncomfortable moments can become teachable moments not only about “good practice” but also about how nurses are embedded in a nest of social relations with others, including other care givers, administrators, patients and their families and how good nursing practice requires attention to the diverse contexts and structures framing health care.

As all faculty members are nurses, there is also an underlying assumption that their professional code of ethics directs them to act when they see compromised care. As a guest at the care facility, they may be unable to take action at the moment and may face “moral distress” as defined by Pauly, Varcoe and Storch (2012). “Moral distress” is specifically associated with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties. But there is also the corollary that at the moment that care is compromised, there is also an opportunity to act. That action can perhaps help to create a small change in practice, be it in the student who carries that small change with them after graduation or in the practitioners affected by the action at the time as well as in the nursing faculty. Small changes over time can have a cumulative impact.

1.2 Purpose & Guiding Questions

The purpose of this qualitative study is to explore how nursing faculty make meaning of their experiences of the disjuncture between what is taught about best practice in nursing schools and nursing practice found in many clinical practice sites that do not meet these standards. The goal of this exploration is to point to some educational and action-oriented

interventions to assist faculty and students in navigating the liminal space of the practice-education intersection.

The personal goals that I hoped to accomplish by doing this study are as follows. Intellectually, I wanted to more fully explore the meaning of the experience of teaching nursing students faced with reality at the practice-education junction. Practically, I hoped to better advocate for changes of existing conditions by understanding the faculty actions and contexts more deeply. Finally, I feel a professional responsibility to try to direct the education of nursing students to improve conditions for patients. It is important that we prepare new graduates to be caring, empathetic nurses who are able to advocate for people and for each other; nursing students need to become knowledgeable about the complexities of health care and the structural constraints facing the provision of good health care.

1.2.1 Guiding Research Questions

1. What meaning do individual nursing faculty members give to their experiences of the disjuncture between what is taught about ethical and best practice in nursing and nursing practice that is found in many clinical practice sites?
2. How do individual nursing faculty members navigate the disjuncture between practice and education?
3. What can these stories contribute to nursing curriculum and the preparation of nurses as advocates for change within the health care system?

1.3 Theoretical Approach

I am using both a critical and social constructivist approach to explore the practice-education disjunctures and to guide my analysis. Kincheloe and McLaren (2005) discuss how

there are many different critical theories and that the critical tradition is always changing and evolving. They list some commonalities among critical schools of thought with the underlying basic assumptions made:

All thought is fundamentally mediated by power relations that are social and historically constructed; that facts can never be isolated from the domain of values or removed from some form of ideological inscription; that the relationship between concept and object and between signifier and signified is never stable or fixed and is often mediated by the social relations of capitalist production and consumption; that language is central to the formation of subjectivity (conscious and unconscious awareness); that certain groups in any society and particular societies are privileged over others and, although the reasons for this privileging may vary widely, the oppression that characterizes contemporary societies is most forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable; that oppression has many faces and that focusing on only one at the expense of others (e.g. class oppression versus racism) often elides the interconnections among them; and, finally that mainstream research practices are generally, although most often unwittingly, implicated in the reproduction of systems of class, race and gender oppression. (p. 304)

A social constructivist approach, which assumes that reality is constructed by social interactions between people and the society in which these interactions take place, allows me to investigate the stories that faculty shared with me about practice-education disjunctures and the relationships that influence the outcome or the impact of the disjunctures. The

collected stories reflect a reality constrained by a range of social resources and circumstances. A critical lens expands this social constructivist approach and investigates overt and hidden relations of power, the assumptions that are made around issues of politics, culture, history and structures in the hospital setting where the practice education disjunctures take place. A critical lens can focus on resistance and alternative actions that faculty and students do and could make in the face of disjunctures.

The main theorist informing my approach is Dorothy Smith (1992, 2005, 2006) a feminist sociologist who has developed “standpoint theory” and an investigative approach entitled institutional ethnography. Smith developed institutional ethnography as a method of inquiry to examine social relations and social institutions that structure people’s everyday lives. Institutional ethnography is a process to discover how people’s everyday activities are coordinated by dynamics beyond any one individual’s everyday experience. Institutional ethnography is applied to local contexts to uncover evidence of the greater social relations that unknowingly coordinate people's everyday activities. Every day activities are analyzed for a deeper understanding of the unseen agenda driving these actions. Smith (1992, 2005, 2006) contends that social relations coordinating everyday activities across time and space are hidden from people and that people unconsciously support and reproduce the invisible coordination.

Historically, it was the advent of widespread availability of print from the mid-19th century that enabled new ways of social organization. This development disrupted the traditional use of knowledge where individual managers or owners of businesses using their accumulated experiential practical knowledge made decisions. Decisions in the 20th century became decisions based on collected data. Discussions based in established relationships

were replaced by written rules and procedures and administrative practices. This trajectory has continued to the point where we are now ruled by unseen corporations, governments, public bureaucracies and other organizations external to everyday activities (Smith, 2005). Smith (2005) is informed by the theoretical thinking in the ontology of Marx, Mead, and Bakhtin. Marx looked at work and questioned how work is coordinated, that is, how others coordinate what an individual does. As a contemporary example, the fashion magazine industry creates an image of femininity, which is then accepted by people, including young women, as the ideal. The images are created to market products but the women emulating the magazine images are seemingly (or choosing to be) oblivious to the coordinating effect of the beauty industry on their everyday lives. (Smith, class notes Jan 11, 2010). Smith notes that there is always social organization of people's everyday activities that is an ongoing and purposeful regulation of people's everyday activities by unseen external factors. Everyday activities are socially organized and people often participate in this unconsciously because the social organization may not be visible. The coordination happens without explicit knowledge of the people carrying out everyday activities (Smith, 2005). The everyday world of work is studied in detail to understand what is really happening from the local level to the global level.

Smith (2005) writes: *...we are ruled by people who are at work in corporations, government, professional settings and organizations, universities, public schools, hospitals and clinics, and so on and so on. Though they are, of course, individuals, their capacities to act derive from the organizations and social relations that they both produce and are produced by. The relations and organization in which they are*

active are also those that organize our lives and in which we in various ways participate.... (p. 18)

Smith (1992, 2005, 2006) describes a key aspect of her standpoint theory as “ruling relations.” The ruling relations are forms of consciousness and organization that are constituted externally to particular people and places. Uncovering the “ruling relations” reveals how knowledge is socially organized. Empirical linkages among local settings of everyday activities and translocal organizations, governance and administration are investigated in an institutional ethnography. Smith names these linkages as “ruling relations” because these linkages form a complex network of coordination. This coordination is unseen and is increasingly in textual forms, and Smith sees these forms as a location in which power is generated and maintained. Campbell and Gregor (2008) explain that the notion of explicating the ruling relations from the experiential accounts of the individual is at the analytic core of the research process. Ruling relations are defined as:

... the distinctive translocal forms of social organization and social relations mediated by texts of all kinds (print, film, television, computer, and so on) that have merged and become dominant in the last two hundred years. They are objectified forms of consciousness and organization, constituted externally to particular people and places and relying on textually based realities (p. 27).

Smith believes that knowledge is socially organized and seeks to uncover how knowledge relates to power and by whom and what knowledge is organized. By participating unconsciously in social relations that are relations of power, the knower is being dominated by the organization/institution. Understanding how texts within an institution are dominating individuals allows one to plan resistance and action. In institutional ethnography, power is

seen as embedded in texts that organize the nurse's work and relations between nurse and patients and nurse and administrators. Texts have the power to direct people's activities and lives in a selected way. Thus, the texts are named as "ruling." Nurses routinely work actively with all sorts of forms, consents, checklists, reports and records. The intent of institutional ethnography is to discover and to explore the operation of power and knowledge in people's everyday organized activities.

Many nurse researchers have taken up institutional ethnography as an approach to study nursing practice, such as Rankin (2003), Rankin and Campbell (2006), Campbell and Gregor (2008), DeVault and McCoy (2006), and Rankin and Campbell (2009); more discussion of these studies can be found in Chapter Two. Literature conceptually framed around institutional ethnography addresses the two contexts in which nursing faculty members are located: health care and education. Rankin and Campbell (2006) use an institutional ethnographical approach to illustrate how the practicalities confronted by caregivers in their everyday routines may make it impossible to carry out best practices as taught in nursing schools. McCoy (1998) describes how ruling relations of business sustainability practices have changed public post-secondary institutions, and Rankin and Campbell (2006) describe how the same ruling relations have subordinated nurses' knowledge.

Standpoint theory has been criticized as not addressing race, class and gendered differences. Smith's (1992) response was to reiterate that standpoint theory was not a theoretical construct but rather, a place in which to begin inquiry. She stated that the inquiry began with the knower and the actual location of the knower. The knower acts, feels and

experiences within a network of social relations linking the knowing subject's activities to those of other people in ways that are invisible. The knower could be any race, class or gender. In *Institutional Ethnography: A Sociology for People* (2005), she recalled how the women's movement was foundational to her thinking about standpoint from the perspective of women but that it has to work for both men and women, thereby renaming it a sociology for people. Smith also informs my methodology in that I begin with the everyday world as understood and experienced by the knower, that is, nursing faculty.

The stories that faculty members shared with me in the interviews describe the daily activities of faculty and students in the practice-education disjuncture situation. They provide cues as to the social and institutional relations that are invisible in the everyday but shape it nonetheless.

1.4 Methodological Framework

There are certain philosophical, ontological, epistemological and axiological assumptions made when one undertakes qualitative research (Creswell, 2007). The philosophical assumptions that I am making are the following. Ontologically, reality is particular to an individual and is affected by personal views and past experiences. I am not arguing for a subjectivist position but rather accepting Dorothy Smith's precept that women are the subjects of their lives not the objects of inquiry. Dorothy Smith states that the starting point for research is the understanding of lived experience of everyday reality from the woman's perspective. Because reality is particular to an individual, it can be varied as the unique participants describe their everyday experiences. However, following Dorothy Smith's ideas, I am also assuming that within their individual narratives, are clues about how the everyday experience for each participant is organized by social and institutional relations extending

beyond the everyday. Epistemologically, as a nurse educator myself, I have access to “insider knowledge”; and axiologically, I recognize that research is value laden, that bias is present, and that I need to clarify my position in this study.

1.4.1 Insider Status

In qualitative research, the researcher is part of the social world that they are studying; a researcher needs relationships that allow ethical access to information and the relationship is the means by which research gets done (Maxwell, 2005). The relationships are informed by philosophical, ethical and political issues and are dependent on particular contexts. I am on the nursing faculty at a community college in a large urban area and I am a registered nurse. I have worked as a nurse educator in the college setting for 20 years and practiced as a registered nurse in hospital and community settings for 20 years. I am an insider to the profession of nursing and an insider of the college organization. As part of the nursing faculty, I have experienced and heard many stories reflecting the disjuncture of practice and education. My current role allows me to be in contact with students and nursing faculty in both classroom and clinical settings. It is sometimes disheartening to be a nurse when I hear the narratives of depersonalization and disrespect faced by some patients. Often it is the elderly who are the most vulnerable because ageism is ubiquitous. In another role, not as an insider but as a public consumer in the health care system, I have experienced both excellent and inadequate practices. Recently, I have observed my aging parents experience increasingly frequent hospitalizations and struggle during their hospital stays to maintain their personhood. This is a story of my mother in a large urban hospital.

M., a feisty 90 year old retired librarian lived with her husband in a small apartment and together, they fiercely protected their independence. She was almost blind

without her glasses and was hard of hearing without her hearing aids. Her husband used a cane and walked slowly and painfully. They used to joke that together they made one person, she could walk and he could see and hear. One day, she had to be hospitalized because of right-sided heart failure. No one seemed to be aware that she was hearing and vision impaired without her glasses and her hearing aids. Very few of the hospital caregivers assisted her access to her glasses or hearing aids. She was incorrectly labeled as cognitively impaired and when she tried to climb out of bed to get to the bathroom, she was restrained. Her 90-year-old husband came into the hospital room while she was agitatedly trying to get out of the restraining chair. She said, "I have to go to the bathroom." Her husband went to find a nurse who came into the room and said to Mrs. M., "You don't need to go to the bathroom, you are wearing a diaper." Mrs. M.'s husband said, "Why would she go in a diaper if she has never had a diaper on before? She needs to get to a bathroom." The experienced nurse said "Oh?" and walked off without helping. A student nurse witnessed this exchange and stepped in and offered M. a commode which was gratefully accepted. The bathroom was not really accessible; it had been built so that when the curtains were drawn around the roommate's bed, it cut off the bathroom entrance and one would have to enter the roommate's space behind the curtain to actually use the bathroom. Adding another complication, the other person in the room was male.

In this story, fortuitously, there was a student nurse from my college present and she was able to help, but as we left the unit for the day, we were both distressed by our inability to change the situation for my mother knowing that she would continue to have problems accessing the bathroom and the staff would continue to consider her as a confused person.

These experiences have shaped my decision to choose this topic as I try to understand the experience of educating nurses in a context of inadequate practice.

1.5 Research Methods

The paradigm that reflects my worldview and informs this study is one of social constructivism as described by Creswell (2007). That is, in the social constructivist worldview, I seek an understanding of the world that I live in and understand that subjective meanings of experiences are negotiated socially and historically and formed through interactions with others. My research method, using Dorothy Smith's approach, is to listen to participants' stories/narratives of the practice-education disjuncture within the context of their everyday lives in order to understand the social and institutional relations that are invisible in the everyday settings of the participants. My approach, informed by institutional ethnography, reveals the institutional power relations that are hidden in the activities of everyday life. My intent is to make sense (to interpret) the meanings nursing faculty have about their world in the disjuncture between practice and education. Social constructivism is often combined with interpretivism. The interpretivist approach to research is underpinned by the assumption that my perspective is shaped by my personal experience, location and lens.

Chase (2008) explains that everyday activities construct the social world for individuals. There are constraints in the everyday social world, but it is not entirely imposed; that is, people act with some autonomy within the system and create their own roles. Everyday activities involve people interacting with other people rather than being in isolation. Meanings are created through interactions and involve people's interpretations that

are not static but changing over time and become shared understandings through a process of negotiation (Chase, 2008).

Thus, I am investigating the meaning of the faculty experiences of the disjuncture at the practice-education interface by collecting narratives of the everyday activities of 24 nursing faculty in the clinical setting. I am using the term “narrative” as a synonym for “story,” and throughout this paper, the terms are used interchangeably. There is a generative or inductive pattern of eliciting meaning from narratives. More detail about my research approach is provided in Chapter Three.

1.6 Dissertation Outline

This first chapter introduces the study’s problem and significance, purpose, research questions, and the theoretical and methodological approaches that guide this study. The relevant literature is presented in Chapter Two. Further discussion of the theoretical approach, methodology information and an account of data generation activities are presented in Chapter Three. Chapters Four and Five are thematic analysis and in Chapter Six, the themes are reconsidered in light of the key theoretical lens. Conclusions, recommendations and suggestions for further study are found in Chapter Seven.

Chapter 2 Literature Review

2.1 Introduction

Social and institutional relations that extend beyond the everyday shape the everyday world of staff nurses, faculty and students where practice-education disjunctures occur. Power dynamics, which affect these relationships, are found in all aspects of nursing practice and education. Consideration of context is vital because contexts shape nursing practice and practice-education disjunctures. Using Dorothy Smith's approach, both the local context and the wider context in which nursing practice takes place needs to be considered. Thus, the literature review is divided into two parts.

In the first part of the literature review, related studies that reflect the everyday world where practice-education disjunctures occur are considered. The everyday actuality of nurse faculty is reflected in the research around: reality/transition shock, moral distress and incivility. In the second part of the literature review, I shift attention to the larger or "extralocal" context in which nursing practice-education disjunctures take place, focusing on the origins of nursing as a profession, some of the major changes affecting the health care system and hegemonic practices. Given the similarities in curricula, specifically the inclusion of practica in the education of other professionals such as teachers and social workers, related literature from those fields has also been reviewed.

2.2 Exploring the Everyday: Practice-Education Disjunctures

In the current state of health care in Canada, nursing faculty members' experiences of practice-education disjunctures are common (Rankin & Campbell, 2006). Studies that have focused on disjunctures have been variously conceptualized as reality or transition shock and

moral distress. Another arena of research that takes up the consequences of these struggles can be found in research of incivility found in nursing practice.

I also looked at the literature from other countries with socialized health care systems such as Australia, Britain and New Zealand to see if this experience was also evident. However, the role of nurse faculty as instructors in a clinical area varies in different countries. For example, in Australia, students in clinical experiences are taught by staff nurses who are employed by the clinical agency in which the clinical experience is taking place rather than by nursing faculty from separate independent educational institutions.

Paton (2005), from New Zealand, writes about using Heidegger's Unready-to-Hand concept to look at the experience of eight nurse educators who managed student learning in less-than-ideal contexts. She suggests that further research needs to be done on how nurse educators sustain themselves through situations that overlook their expertise and skill as a registered nurse. She writes that,

...nurse educators teaching in the clinical environment are called to make sense of and respond within complex and unpredictable clinical situations. Deciphering what is in the call requires an openness and confidence to attune to what is going on, often shifting cognizance to unravel subsidiary knowing, while observing and pursuing questions that simultaneously add clarity and dismiss certainty.... (p.58)

Although this content is relevant to my study, this research is set in New Zealand where there is a slightly different context of practice and roles for nurse educators. Warne, Johansson, Papastavrou, Tichelaar, Tomietto, den Bossche, et al. (2010) in a survey of nine European Union (EU) countries (including England) found that the faculty role was not consistent across the EU and that the role was evolving in several countries. They found that the role of

faculty was more of a liaison role between students and the clinical staff mentors/supervisors. In Canada, this type of experience, in which there is supervision by clinical staff, would be more like a capstone preceptorship experience in which faculty regularly visit the students and preceptors who are staff nurses.

2.2.1 Reality or Transition Shock

The impact of structural components of the work environment in shaping nursing practice is evidenced in the research that has explored the “reality shock” of new graduates as they move from the student role to the graduate nurse role, which has been identified as the academic-practice gap. This academic-practice gap is similar to the practice-education disjuncture in that, what has been learned at school is not what happens in the “real” world. Kramer first wrote of reality shock in 1974. She explained that when an individual moves from one subculture to another, reality shock occurs; newcomers to a work role that they have spent several years preparing for find that they are not as prepared as they thought. The new professional finds that many of the ideals and values to which they were socialized in the school setting are not operational in the work setting (Kramer & Schmalenberg, 1977).

Kramer’s “reality shock” (1974) is still present although now called “transition shock” in Canada (Duchscher, 2001). Gordon (2005) reported that when she interviewed nursing students at McGill University, they were clearly distressed about what they had been taught about autonomy and power and the reality of the daily subordination that they witnessed during their clinical experiences. McIntyre, Thomlinson and McDonald (2006) found that there is an incongruity between what nurses are prepared as professionals to do and what they are expected to do in practice. In the UK, Maben, Latter and MacLeod Clark (2006) found that new graduates were unable to practice as they had been taught and experienced

frustration and disillusionment because their ideals and values were thwarted. Duchscher (2001) found the same issue with a group of newly graduated nurses in acute care hospital settings in Canada.

In 1977, the attrition rate of new graduate nurses in the USA was approximately 34% (Kramer & Schmalenberg, 1977). Thirty years later in 2007, attrition of new nurse graduates in the first year of practice continues to be a problem. There are differing statistics on attrition in the USA, from a high of 30% (Newhouse, Hoffman, Suflita & Hairston, 2007) to a low of 13% (Kovner, Brewer, Fairchild, Poornima; Kim & Djukic, 2007). However, all agreed that the most common cause of attrition is the negative working conditions on hospital units.

There are similar problems in Canada, where retaining nurses continues to be a current problem (Laschinger, Wong & Grau, 2013). These authors call for theory-driven, relationship-oriented leadership strategies that would address structural empowerment to attend to problems in current work environments that affect patient care.

2.2.2 Moral Distress

Closely related to issues of reality or transition shock is moral distress that is linked to the inability of nurses to provide best practices due to system constraints. As a guest at the care facility, nurse faculty face “moral distress” as defined by Pauly, Varcoe and Storch (2012). “Moral distress” is specifically associated with the ethical dimensions of practice and concerns related to difficulties navigating practice while upholding professional values, responsibilities and duties. This has become a phenomenon of increasing concern in nursing practice, education and research. There is a body of quantitative and qualitative research on nurses’ moral distress, which has been linked to the lack of resources and health care

system's economic and political structures. For example, Pauly, Varcoe, Storch and Newton (2009) found that ethical climate, along with five influencing factors (peers, patients, managers, hospitals and physicians) were significantly correlated with moral distress. These authors noted that the moral distress of nurses has also been associated with staff conflict, attrition and patient safety. A study by Varcoe, Pauly, Storch, Newton and Makaroff (2012) also looked at situations of moral distress and the response of nurses. They found that nurses identified broad systemic factors of workload and incompetence of self or other health care providers compromising care. Most nurses in this study reported taking action to address the situation. These authors suggest that in the development of future research on moral distress, theoretical frameworks underpin and guide such research ... *"grounded in a conceptual understanding of moral distress that reflects both moral agency and structural relationships, and the interactions between the individual's experiences and the structural features..."* (p. 55). This statement supports the notion that the context (structure) is a key factor in shaping nursing practice. Individual agency is not separate from structure and both elements are intertwined.

In the educational literature there are related themes of ethics education and ethical behaviour of students. From an educator perspective, students learning about ethical practice is inarguably a vital part of becoming a nurse; how nursing faculty members navigate the practice education disjuncture provides an opportunity to role model ethical practice. Haigh and Johnson (2007) identify the importance of moral agency of teachers related to interactions with students. In the nursing literature, ethical academic behaviour is often linked to ethical practice behaviour and some aspects of education and practice interface are referred to in general ways. Varcoe and et al. (2004) describe how practicing nurses see their

ethical practice as relational and contextual. The respondents in the Varcoe et al. study (2004) described how they worked in between their own values and the values of others. The competing values and interests found their everyday nursing practice was often a struggle between *“their identity as moral agents by doing what they saw as ‘good’ while contextual forces constrained their ability to choose and act in ways they deemed ethical.”* (p.319)

The faculty members’ experiences of disjuncture are located within the everyday activities of staff nurses. The perceived presence or absence of ethical care by staff is relevant to how faculty negotiate the disjunctures. Feminist relational ethical theory brings important attention to the need for authentic dialogue within the caring relationship and the significance of context in ethical decision-making (Lutzen and Pergert, 2012). The context or structural features of disjunctures are significant and will be addressed in the analysis in Chapter 6.

2.2.3 Incivility

Also relevant to this study’s investigation of the everyday nurse faculty practice, is research that explores the presence of incivility or bullying between nurses within health care settings. In my study of experiences of practice-education disjunctures, studies of incivility and bullying bring attention to particular elements of the difficult and sometimes chilly environments in which nurses are working. Power imbalances create a climate that brews incivility in the workplace. Several nursing unions conducted a study on incivility or bullying in the workplace in which 506 registered nurses, 112 registered psychiatric nurses, and 500 licensed practical nurses took part in a telephone survey (Croft & Cash, 2012). They found that hospitals were layered organizations, with nursing being subordinate to administration, doctors, regulators, and patients. Their findings support the idea that oppressed group culture

is reproduced in most clinical settings. Croft and Cash (2012) report that the current business model, with focus on cost containment, downsizing, skill mix changes, and decentralization, has created feelings of disenfranchisement and workload issues. Other issues found in the study were a lack of interpersonal and management skills by nurses.

Buresh and Gordon (2006) argue that nursing has suffered from years of self-perpetuating professional invisibility. They believe that physicians receive credit for “curing” while that work is made possible by the invisible “caring” work of nurses. Change does not happen because nursing leadership adopts the hegemony of the workplace (Buresh & Gordon, 2006). They suggest using a postcolonial feminist lens to shed light on the ways in which colonizing routines are implicated in the hierarchical relations. As a journalist and non-nurse, Gordon (2005) describes a critical problem with nurse-physician power imbalances, which inevitably leads to conflict. According to Gordon, nurses have become very adept at working around the conflicts because as a group they have not viewed the power imbalance as a major problem. Nursing literature views the physician-nurse conflicts as ethical dilemmas. According to Gordon (2005) this shifting of power issues as ethical compromise puts nurses in a weaker position and reinforces the 19th-century image of nursing as virtue work and perpetuates the idea that nurses are not as important as physicians. Peter, Lunardi and Macfarlane (2004) write that accepting a state of powerlessness can be seen as ethical compromise and that nursing power is identified through acts of resistance.

Hutchinson, Jackson, Wilkes and Vickers (2008, 2010a, 2012b) describe a new multi-dimensional model to understand bullying in the workplace. These authors found that conceptualizing bullying to be between individuals did not address all aspects of a complex phenomenon. They suggested a new model and some interventions based on this model that

would address organizational levels because processes, structures and routines at the organizational level may be perpetuating the bullying behaviour. Hutchinson (2013) and Hutchinson and Hurley (2013) confirm again that bullying exists and affects nurses and the quality of care. They suggest that an emotional intelligence-informed leadership might be a vital variable in mitigating bullying in the workplace.

Incivility in the practice setting is a reality for students and faculty as well. The horizontal violence apparent on the clinical unit is sometimes directed at students and the unwelcoming behaviour is the practice-education disjuncture. Or, if there is a culture of incivility on the clinical unit, navigating a specific practice-education disjuncture becomes complicated.

2.3 Exploring the Extralocal: Wider Context of Practice-Education

Disjunctures

In an institutional ethnography approach, the first level of data collection is the individual account of an everyday experience, and the second level is where the explication of ruling relations happens (Campbell & Gregor, 2008). The researcher needs to find out the missing organizational details of how the broader setting is actually coordinating the local activities (Smith 1992, 2005, 2006). In this section of the literature review, I look at the influences in the wider context where practice-education disjunctures happen. There are historical, economic and hegemonic hierarchical influences.

2.3.1 Historical Influences

The context of practice in which practice-education disjunctures take place is a culture embedded with hierarchical power relations. The issues found in the context of practice have a large bearing on how faculty members navigate disjunctures. Examination of nurses' everyday activities within practice environments offers an opening to engage in questioning and to become mindful of the often-invisible conditions that constrain nurses. In order to understand these power relations, it is useful to consider the historical roots of "western" nursing. Nursing was organized as a militaristic training for women who felt a "calling" to help others. Hierarchy is embedded in the culture of nursing. Originally nurses were educated by and practiced in religious orders and although they did have the power to make decisions on care, they were within a structure of male hierarchy. This religious connection continued to the mid-19th century. During the 19th century, the poorhouses or workhouses became increasingly filled with people unable to work because of physical or mental illness. The lay workers providing the care in the workhouses were uneducated paupers that happened to be more able-bodied than the other residents. At this time, nursing was not seen as a respectable work for women outside of the lower working class. Nurse reformers such as Nightingale lobbied for reform in hospitals and created an environment in which respectable women could work (Dossey, 2000). With hospital reforms it became clear that nurses needed formal systematic education. Nightingale embraced nursing because she had received a "calling" based on her fervent Christian beliefs. When she began to organize women to work in the hospitals, most women did not work outside the family. Gordon (2005) writes that by portraying nursing as a religious calling and by making clear that nurses were subordinate to physicians, Nightingale contributed to the normalization of the

nursing profession as a “calling” and a profession within a patriarchal structure wherein the power was situated in the doctors, and argues that this construct still exists. As an example, when non-nursing groups of students were compared with nursing students, nursing students consistently highly rated the values of altruism and caring, while non-nursing groups did not (Thorpe & Loo, 2003).

This militaristic and “calling” served the nursing community well for a long time in the teaching of procedural skills. But as the health care system started to change, a need to change the curriculum to create graduates with more critical thinking and problem solving skills emerged. Hospital based training programs for nurses changed to schools of nursing in colleges and universities in the late 1960s into the 1970s. Apprenticeship type of training became a college and university level education. Entry to practice requirement across Canada today is a baccalaureate level and nursing practice is located in diverse settings in the community and in specialized settings in hospitals. However, some part of the practice component of nursing education still takes place in the traditional medical surgical hospital settings where the historical roots of nursing are still present.

2.3.2 Neoliberal Corporate Influences

There is continuing global hegemony of neoliberalism (Wilson, Calhoun & Whitmore, 2011). These authors describe a reshaping of public agencies by privatization, de-regulation, free trade and, in general, a drive toward removing barriers to commercial interests. Since the late 70’s a neoliberal ideology has altered the social services by public, non-profit and for-profit organizations (Hasenfeld & Garrow, 2012; Ilcan, 2009; Teghtsoonian, 2009). The increasing reliance on market behaviour by the non-profit human service organizations resulted in the restructuring of public services by business models and the concurrent rise of

for-profit social service providers. Ilcan (2009) describes the neoliberal governmental approach as “privatizing responsibility”: that is, responsibilities for welfare, care and well-being is increasingly delegated to individual family households. The neoliberal view is supported globally by increasing numbers of transnational corporations and organizations such as the OECD and IMF, which promote and identify ways to devolve national administration to local, levels and privatization or market-like governance of public services to increase efficiency and cost containment (Ilcan, 2009).

Since 2001, the right-wing Liberal government in BC has been making neoliberal reforms in health, education, labour relations and social assistance (Teghtsoonian, 2009). In an analysis of government-produced documents about managing depression, Teghtsoonian (2009) found that the attention was paid to the individual with depression rather than to the broader public policies and systematic inequities.

As health care is a public service, the health care system has been re-structured to be driven by a hierarchical corporate model. This has created changes to nursing practice that were not planned for by the nursing profession, but instituted by the corporate drive for accountability and managerial practices in publicly funded health care over the past two decades. This has been identified by several authors: Laschinger, Finegan, Shamian, and Wilk (2001); Stein (2001); Rankin (2003); Lindsay (2004); and Gordon (2005). The result is an evolution of nursing practice from a patient-focused care delivery model to an efficiency-focused cost-effective model. Rankin and Campbell (2006) found that over the previous two decades, nursing practice in hospitals has been slowly and significantly restructured by managerial solutions to problems. This managerial/business viewpoint does not necessarily take into account the perspectives of nurses or other care providers such as care aides and the

managerial/business position has created a practice arena with problems for both health care providers and patients. Nursing faculty members are faced with difficulties of navigating the practice arena that may be structurally unsupportive of health care providers and patients while trying to teach nursing students about best practices. Rodney and Varcoe (2002) report that Canadian health care reform over three decades was driven by neoliberalism and corporatization as part of economic globalization and has created worsening work conditions for all health care workers. These work conditions affect the care that nurses can provide to patients.

The reorganization of the health care system by corporate ideology has made it difficult for nurses to provide care in a caring and holistic way as they are taught. This reality of practice is a significant determinant of practice-education disjunctures.

2.3.3 Hegemonic Hierarchical Influences

As noted in Chapter 1, this study is informed by critical theory and its orientation to social relations of inequality and how power is operating to maintain structures of domination. Power can be viewed as relational or structural or an interplay between agency and structure (Gaventa, 2006). Young (1990) considers power to be relational and can be hidden, visible or invisible. Power issues shape both every day and extra-local activities of staff nurses and nurse faculty members.

Nurse Power

Nurses are often portrayed as being less powerful than some other members of the health care team. Manojlovich (2007) describes nurses as powerless relative to organizational administrators and medical staff so nurses do not have control over the content or context of nursing practice. She concludes that the feminist movement of the 1960s did not change

health care hierarchy and nursing's low status remains. In a 1995 literature review, Gilbert (1995) found that there were 378 papers in the CINAHL database identified as discussions of empowerment, but no consensus or clear understanding of the concept of empowerment or power existed in these. Years later, Daiki (2004) discovered the same.

The literature about empowerment of nurses in hospital settings (Laschinger, Finegan, Shamian & Wilk, 2001; Siu, Laschinger, & Vingilis, 2005; Faulkner & Laschinger, 2007; Manojlovich, 2007; Bradbury-Jones; Sambrook, & Irvine, 2008) focuses on ways to empower nurses. But looking at this literature with an institutional ethnography perspective, it seems that “empowerment” has been appropriated by business models in which the administration places blame on individuals when the “system” is not working. The strategies are directed toward managing nurses’ frustrations, not at addressing the root causes and concerns of nurses about their ability to carry out their work. A root cause is the corporatization of health care leading to unmanageable workloads for all health care providers.

Fletcher (2006) writes ... *“Yet, despite what we know, nursing is still challenged by negative stereotypes and nurses are not empowered—what we are doing as nurses and nurse leaders does not seem to be working.”* (p. 51) Fletcher believes that we need to re-examine our beliefs and not to engage in dualistic thinking of acceptance or resistance to the technical skills medical model. She suggests that nursing leaders have gone from the medical model to the male business model and neither model are close to the relationally oriented, feminist model of empowerment; nursing is inherently linked to the power issues that affect women in our culture. She recommends that nurse leaders become aware of the structures and cycle of oppression.

Perron, Fluet and Homes (2005) disagree with the rhetoric that nursing is powerless and that nurses are consequently apolitical agents. For these authors, nursing as a profession is at the heart of what they name as bio-power. They use the work of Foucault with regard to bio-power and suggest that nurses are at the converging point of individual and community needs and aspirations. In this model, nurses do have the power to regulate and can be a political entity.

Education and Nurse Power

Nursing education is itself, a hegemonic and hierarchical context. Using Foucault's approach to power, Bradbury, Sambrook and Irvine (2008) suggest that the concept of power in nursing can be linked to Foucault's notion of disciplinary power and the intertwining of knowledge and power. They encourage educators to adopt a more critical stance to understanding power and empowerment in nursing through the use of post-structural lens. Similarly Darbyshire and Fleming (2008) used a Foucauldian lens to describe how all teacher-student contacts have the capacity to govern. They argue that nurse education is not a neutral space where students are empowered or made autonomous learners, but rather, it is a domain of governmentality that differs with what is stated in the curriculum and in academic and research literature. To address this, Bevis and Watson (1989) introduced the "emancipatory nursing curriculum" that was used widely in Canada, United States, United Kingdom and Australia. In the emancipatory nursing curriculum, students were acknowledged as equal partners in the educational enterprise, and it was intended to restructure the way that faculty and students related to each other. Curriculum was defined as interactions between and among students and teachers with the intent of creating empowered students who would subsequently become empowered practitioners. Falk-Rafael, Chinn, Anderson, Laschinger

and Rubotzky (2004) found that feminist pedagogical processes used in a nursing course did increase students' classroom empowerment; the authors were hopeful that it would extend beyond the classroom to empowerment in personal and work environments. However, there is little evidence that this has taken place in a significant way (Gordon & Buresh, 2006).

Randall, Tate and Loughheed (2007) from North Island College in British Columbia discuss some of the tensions associated with teaching and learning in an acute care context and their experiences of navigating the tensions between what their emancipatory curriculum teaches the students and what is actually happening. They argue that an inquiry approach to teaching, one that makes the inquiry visible to staff members, is one way to navigate the tensions. While they do not focus on the experience of faculty, they discuss a strategy that can help faculty navigate in clinical arenas that are not supportive of the underlying philosophy of an emancipatory curriculum.

Transformative learning based on critical theory is suggested as a way to create student self-awareness of the oppression. One inroad is to make use of the legitimate power of patient advocacy. Freshwater (2000) challenges nurse faculty to view teaching as a moral activity and consider the subtle social and political messages within everyday clinical practice that may be going unnoticed.

Oppression

The incivility mentioned previously as part of the everyday context of nurses is linked to the larger concept of oppression, an "extralocal" aspect of practice-education disjunctures. Historically, nurses have been in subordinate positions given that nursing is a gendered field where most nurses are women. Oppressed group behaviour by nurses in their workplaces has

been documented in nursing practice, administration and education for over 30 years (Roberts, Demarco & Griffin, 2009). Young (1990) considers power as relational and maintained through an ongoing series of social interactions. Her notion of cultural imperialism, in which there is universal acceptance of the dominant group's culture and experience represented as the norm and seemingly non-contestable, can be applied to nursing practice settings. This form of systematic oppression may not be at conscious level, but it survives in hospital settings (Gordon & Buresh 2006; Laschinger, Finegan & Shamian, 2001; Faulkner & Laschinger, 2007). Horizontal violence or bullying by nurses to each other in hospitals has been documented (Laschinger, Finegan, Shamian & Wilk, 2001). Freshwater (2000) found that horizontal violence happens between nurses because of a system that has excluded them from power. She argues that educational programs may be perpetuating the oppression cycle as,

...the cultural narrative in nursing is to be subordinate. Going against the cultural narrative requires energy and when nurses are tired, and recruitment and retention are at their lowest, where does the nurse get the assertive and emancipatory energy to challenge the cultural narrative? (p. 483)

Roberts, Demarco and Griffin (2009) reviewed literature from 1983 to 2007 for interventions to change oppressed group behaviours on the culture of the nursing workplace. The presence of oppressed group behaviours has been related to decreased nurse self-advocacy, horizontal violence and silencing of the self. They describe the oppressed group behaviour from a systems perspective. Freire (1971) as cited by Roberts, Demarco and Griffin (2009) theorized that the basic reason for these behaviours is that dominated people feel devalued in a culture where the powerful promote their own attributes as the valued

ones. The oppressed, therefore, develop disdain for themselves and a belief in their own inferiority that leads to a lack of pride and feelings of low self-esteem. Oppressed people try to become like the dominant group and become marginalized because they are not members of either group and therefore have no sense of unity. Nurses silence themselves to avoid conflict and to maintain the status quo. Horizontal violence, inter-group rivalry, lack of unity and pride, and aggression turned inward are all aspects of the oppressed group model that have also been described in the nursing workplace and academia. Roberts, Demarco and Griffin (2009) do not blame nurses for horizontal violence, because they believe that the behaviour is created by an unequal power balance and maintained by a cycle of oppression that keeps nurses regulated.

The corporate agenda has created a workplace where unregulated care providers have replaced nurses. Nurses are aware of the power issues within their workplace but feel threatened. Daiski (2004) conducted in-depth interviews with 20 staff nurses from large urban hospitals and found that the nurses were aware of the hierarchical relationships between doctors and nurses, between managers and nurses and between nurses themselves. The participants recognized that they were adding to their own oppression by maintaining the nurse-to-nurse lack of support. Daiski suggests that the norm in the education of nurses is to stress conformity and obedience, which produces graduates who accept their place in the hierarchy thereby inviting a continuation of subordination and a lack of autonomy. She proposes nursing curricula should include historical issues of feminism, patriarchal power relationships, non-hierarchical leadership and empowering strategies.

2.4 Do Other Professions Experience Disjuncture?

I looked at other professional education programs of social work and teacher education because both have field experiences, which are similar to nursing education. Students in these professional programs face similar practice-education disjunctures as nursing students. Hurlock et al. (2008) reported on a three-year study of four professions with field experiences in the final year of the university programs. The four professions were education, medicine, nursing, and social work. Their findings uncover the complexity of professional education. There were interconnected themes of silence, power and disillusionment of the profession that they were entering. However, the relationship of faculty in social work and teacher education is different than in nursing education. In social work and teacher education field experiences, the students are assigned to a teacher or social worker actually working in the field, with continuing guidance from faculty. It differs from nursing education in that the faculty members are not leading the student group but are available for consultation, whereas nursing education utilizes instructor-led student experiences in which both the instructor and the students are in a liminal space.

However, some of the strategies that both social work and teacher education suggest for new graduate teachers or social workers to adjust to their workplace could be adapted. Phelan et al. (2006) described how teacher candidates are caught between the demands of what they believe they ought to value and what the experienced teacher professionals tell them that they should value. Phelan et al. (2006) share the viewpoint that teaching is a political activity and is relevant to nursing faculty. Parallels could be drawn between teacher candidates advocating for children with social, cultural, language or economic inequities and student nurses or nursing faculty advocating for elderly, vulnerable or non-verbal patients.

There is also a related body of teacher education literature that has explored teachers as activists for social justice and equity issues (Ayers, Quinn & Stovall, 2008). Kelly and Brandes (2010) describe a teacher education project in which an anti-oppression educative approach was used by student teachers to help them understand and challenge existing inequities. Five recommendations are made to increase the focus on social justice and to assist student teachers to reflect on their own practice as a central part of teacher education. Some of these recommendations could be applied to nursing education. Jacobs' (2006) study looked at supervision of preservice teachers with the goal of increasing awareness of the preservice teachers in practice of issues related to changing multicultural demographics in classrooms and the role of the teacher in addressing inequities. Jacob (2006) writes that, *"Future teachers may not have the experience to engage in critical reflection without the support from someone such as a university supervisor who can model this way of thinking."* (p. 37). Lane, Lacefield-Parachini and Isken (2003) studied an approach of arming graduates to reform urban public schools. They write about the challenges novice teachers face which are similar to the challenges new nurse graduates face but the nurses are in a different context of a hospital rather than a school. The main finding from their study was that student teachers became change agents and had an impact on the mentoring teachers. The student teachers were supported by the teacher education program at the university as well as the principals in their schools in their critical reflection of their own practice and the practice of their mentoring teacher. The critical reflections were shared with the principals and the mentor teachers. The student teachers did not waver even when faced by mentors with different views on social justice. This approach may be applicable to nursing students and faculty in similar practice-education disjunctures. Korthagen, Loughran and Russell (2006) developed

some fundamental principles for teacher education that they suggest is a way for willing teacher educators to reconstruct teacher education from within. Their findings of structures maintained and perpetuated over decades is similar to findings of nurse researchers.

There has been a remarkable development of the knowledge base for teaching through extensive educational research over the last four decades. Nevertheless, the theory-practice issue seems intractable: telling new teachers what research shows about good teaching and sending them off to practice has failed to change, in any major way, what happens in our schools and universities. Neither has having teachers write behavioural objectives nor did exhorting them to be reflective practitioners produce major leaps forward. At the same time, exploring fundamental assumptions of teacher education associated with its university context has proven difficult to achieve. (Korthagen, Loughran & Russell, 2006, p. 1038)

2.5 Chapter Summary

How do nurse faculty members negotiate the practice and education disjunctures found in clinical placements? The context of the clinical placements shapes the negotiations. The context can be viewed from an everyday level of social interactions and at an “extralocal” level. In the first part of the literature review, the impact of reality/transition shock, moral distress and incivility, which shape what Smith would call the everyday experience of staff nurses and nurse faculty, was explored. The literature about the troubled everyday context of practice for nurses supports the view that the context is rife with practice-education disjunctures. In the second part of literature review, the “extralocal” or historical, economic and hegemonic practices shaping the context in which practice-education disjunctures happen, were explored. I can see that practice-education disjunctures are embedded in

extralocal influences of the historical roots of nursing, the neoliberal corporate restructuring of the health care system with negative consequences, and the power imbalances created and sustained by hegemonic hierarchical influences.

I additionally included research from other professional fields of education and social work as these educational programs have a field practice component similar to nursing. Faculty and students from education and social work programs often face the same issue — what is taught in professional programs is not necessarily seen in practice. This literature points to the possibility of using learning from other professions to assist nursing faculty in navigating the disjunctures.

In the next chapter, I will describe the methodology used in this research project.

Chapter 3 Methodology

3.1 Introduction

My study is informed by constructivism/interpretivism and critical theory paradigms. Using critical theory brings into view the larger social, historical, economic and political issues within practice and education contexts. Critical theory involves a critique with the intent to empower people to work collectively to overcome the constraints that may be placed upon them and to effect social change. I am studying how nurse faculty members negotiate practice-education disjunctures and how they create opportunities for change from possible teaching moments within this space.

My methodological orientation is qualitative because it is helpful for understanding the meaning, context and process by which events, actions and behaviours happen. As noted in Chapter One, Smith (2005) contends that reality is constructed by social interactions between people within a society and her methodological approach begins with how people, particularly women, experience the everyday. Specifically, the qualitative approach I used was semi-structured interviews, which allowed me to engage in conversation with nursing faculty, inviting them to tell stories about their everyday experiences of these disjunctures. I then analysed their stories using Dorothy Smith's institutional ethnography approach. In this approach, my goal was to generate and to listen to stories of experience, not to arrive at 'the truth'; instead, shared stories create conditions for deeper understanding of shared issues.

For this study, twenty-four nursing faculty members were interviewed about their experience of practice-education disjunctures. I used a narrative form of interview in order to elicit a description of everyday activities from the nurse faculty. The description of their everyday experiences of disjunctures revealed how faculty members struggle to make

meaning of the experience. The collected stories reflect a reality of the nurse faculty. These narratives are then considered with respect to what Smith names as “ruling relations”, which are hidden or invisible forms of power present in the practice education disjunctures. Using an institutional ethnography approach to the narratives, I can investigate the power issues or ruling relations organizing the everyday of nursing faculty members as they encounter and make meaning of education-practice disjunctures.

Qualitative research is an interpretive process. The interpretation starts when the story is selected out of any possible stories and the researcher and the participants share in this interpretive process during the research. In the following chapters, the narratives will be interpreted within theoretical frameworks of social constructivism and critical theory, using a perspective informed by Dorothy Smith’s institutional ethnographical approach.

3.2 Data Generation, Selection Criteria and Recruitment Strategy

3.2.1 Interviews

People organize their experiences into stories as evidenced by people’s every day actions of how they recount their experiences. I chose interviewing as a method because it can draw out narratives that inform the researcher of the respondents’ world through their eyes. Kvale and Brinkmann (2009) discuss a variety of interview forms that are useful for differing research goals. I am using the narrative interview form, which focuses on the stories that nurse faculty members tell of disjunctures. Mishler (1986) as described by Kvale and Brinkmann (2009) states “*narratives are one of the natural cognitive and linguistic forms through which individuals attempt to organize and express meaning and knowledge.*” (p. 153). As a form of data collection, interviews are well-suited to collect the everyday activities of the nursing

faculty in practice-education disjuncture experiences. Moen (2006) describes experience as constructed in the process of interactions and dialogue with others. Experiences are also dependent on the storyteller's past experiences as well as the past experience of the person who is hearing the stories. Through storytelling, the narratives recounted by people illustrate their meaning-making. While the narratives of individuals cannot be generalizable as forms of truth, narratives do have deeper unarticulated meanings that may be uncovered and connected by a researcher. A narrative interview approach addresses the processes of interaction among individuals and allows me as the researcher to position myself and to acknowledge how my interpretation arises from my personal perspectives.

Nurses are comfortable with storytelling as student nurses are socialized into the nursing profession with stories. Stories also have a pedagogical value in that the stories of the disjuncture and how faculty have navigated the disjuncture could be used in developing curriculum to help students as new graduates navigate the disjuncture more successfully. I elicited stories from the participants by asking a specific question, *"Can you tell me about an occasion where you led a group of nursing students and found that there was a disjuncture about what had been taught as ethical and best practice at school and the actual practice found at that clinical agency?"* In most interviews, this question prompted immediate emotional responses as the nurse faculty members narrated a story about their experience of a practice-education disjuncture. Many study participants told more than one story and some of the incidents had occurred several years in the past and others that had just happened.

I also held a focus group interview. Kamberelis and Dimitriadis (2005) suggest that focus group interviews have a synergistic potential and can produce data that are seldom produced through individual interviewing and that the collective accumulated knowledge and

practice generates rich and complex interpretive insights. Thorne (2007) stated that groups are useful to generate a social dynamic. A focus group was used to more fully explore the third question of this project, namely, how these stories contribute to nursing curriculum and the preparation of nurses as advocates for change within the health care system". A group interview can also help to relocate the researcher from the center because it can provide the participants more ownership over the research, thereby facilitating the joint construction of possible solutions from many voices (Kamberelis & Dimitriadis, 2005).

3.2.2 Selection Criteria and Recruitment

I recruited the interviewees by requesting volunteers through an established committee of schools of nursing in the area. Through my contact on this committee, I also had access to the placement coordinators of these schools of nursing. My contact asked the committee members to pass on my recruitment letter and my email address to anyone on their faculty who might be interested in being interviewed. I was looking for faculty members with different lengths of teaching experience because I hoped that this would present a wider variety of stories. I also wanted to recruit faculty who were actively engaged in clinical teaching, because they would be the ones experiencing disjunctures. This was a purposive sample, as I recruited through this committee because they had direct contact with the nurse faculty in clinical placements. The locations of the participants reflect the breakdown in the types of clinical settings in basic nursing education (Table 2). The majority of participants were undertaking clinical teaching in acute care hospital settings, although a few were also working with students placed in long-term care facilities. This reflects the clinical hours in basic nursing education programs. Going through this committee also gave me access to many different programs which provided breadth to the study because each

research volunteer was informed not only by their own personal nursing histories but also by their location in different basic nursing education programs. I also wanted to speak to the faculty that coordinated the placements of instructor-led groups of students. There is usually one faculty person at each school of nursing that coordinates the clinical placements to ensure that they are a fit for the goals of the clinical course. Three of the 24 people interviewed were nursing faculty members who coordinate placements for nursing students. I wanted to hear their perspective about the practice-education disjuncture and their systems-view of placements. They also handle the requests for change to clinical placements if there were too many disjunctures in one placement.

Clinical placements are integrated throughout all the terms in a nursing program. Students go to clinical placements in small faculty-led groups of six to eight students for one to three days per week throughout each term. The clinical placements are varied across a nursing program covering all specialty areas such as medical, surgical, maternity, pediatrics, psychiatry and geriatrics. Clinical placements are key components in educating a student to become a nurse. During a program, students may have 1000 to 1500 hours of clinical experience over four years. The committee that I recruited from drew its membership from a large urban area, so I chose to stay in this geographical area. Faculty members would also have similar experiences in an urban setting, which would differ from experiences in rural settings.

The criteria for selection of the nursing faculty members were:

- Experience of practice-education disjuncture in a clinical setting
- Range of levels of experience from relatively new nursing faculty to those with many years of experience

- Actively engaged in the experience of teaching student groups in hospital settings, either acute care or residential care and/or involved with placement of students
- English-speaking
- From schools of nursing in an urban region

I received replies from 25 faculty members and arranged to interview them individually over a three-month meeting period, July 2011 to September 2011, at mutually agreed upon public locations. I was unable to meet with one of the original volunteers because of time constraints. The 24 nurses interviewed included two to three nurse faculty members from each of the six baccalaureate nursing programs in a large urban area. Of the 24 faculty members that I interviewed, three were not of European descent and only two spoke their language of origin.

3.3 Insider Status

I did not include my own community college faculty in the study because I am in a chair position and faculty report to me, so there is a power imbalance that might affect a free flow of narratives. There are ethical concerns in a research relationship in which power is not equal. I was concerned that some of the faculty would feel that they were not free to disclose as much as they desired about the experience of disjuncture so they were not included in this study. Also as an insider, I was aware that I was bringing in some bias. At each interview, I informed the interviewee that I was also nurse faculty. I made an effort not to make assumptions and questioned aloud any that I was aware of during the interviews. There is an advantage to being an insider because it allowed me to understand the acronyms, the terminology and the structures of their experiences. I believe that the interviewees freely

shared their experiences with me because they felt that I would understand the experiences of disjunctures. My familiarity, however, can also be considered a bit of a disadvantage because I may have not explored some areas assuming that I had understood the meaning of the stories being told.

3.4 Participants

Demographic data such as years of clinical experience, years of teaching experience and education is found in Table 1 below which illustrates that my study participants had a cross-section of experience varying from four months to 33 years. The average number of years of clinical instruction was 13.2 years while the average number of years of nursing practice was 14.2 years and the average combined nursing and teaching practice was 25.5 years. These numbers add assurance that the collection of narratives making up this study does reliably reflect the reality of teaching nursing practice in clinical areas. In the analysis, I selected relevant excerpts of stories from all participants, but five faculty members' excerpts were selected more often than others. Three of these five faculty members were the ones with the most experience and two others with lesser experience were most passionate about the disjunctures and had much to say about their experiences of disjunctures.

Table 1. Profiles of Participants

Interview #	# Years Clinical Nursing Experience	# Years Teaching Experience *	Total # Years as Nurse
1	1	19	20
2	29	4	33
3	16	1.5	17.5
4	9.5 & still working as staff nurse	4	9.5
5	33	11	44
6	3	34	37
7	2	23	25
8	14	29	43
9	13	15	28

Interview #	# Years Clinical Nursing Experience	# Years Teaching Experience *	Total # Years as Nurse
10	17	11	28
11	31& still working as staff nurse	11	31
12	7	2	9
13	8	27	35
14	33& still working as staff nurse	23	33
15	35 & still working as staff nurse	22	35
16	8	24	32
17	23	6	29
18	20& still working as staff nurse	2	20
19	6 & still working as staff nurse	1	6
20	2	1 term	2
21	19	9	28
22	2	8 doing placements	10
23	6	6 (3 years doing placements)	12
24	3	33 (6 years doing placements)	36

3.5 Setting

Faculty members were teaching in a variety of care settings. Table 2 illustrates the variety of settings: acute hospital inpatient units, residential long-term care units and care in community settings.

Table 2. Clinical Placements of Participants

Care Sites	# of Faculty
Acute psychiatric inpatient unit	2
Children's acute care in medium size urban hospital	1
Home care in community setting	1
Long-term residential care unit	1
Maternity unit in large urban hospital	1
Medical or surgical unit in large urban hospital	9
Medical unit in medium size community hospital	2
Population health in community setting	4

The three placement coordinators were not currently practicing in care settings but were in school settings. Two of the placement coordinators as per Table 1 had clinical teaching experience.

3.6 Interview Process

I did two pilot interviews and altered the questions slightly. The final set of interview questions can be found in Appendix A. During the individual interviews, the participants were asked to share stories of incidents of practice-education disjuncture that occurred while they were supervising students in the practice setting. Participants provided information about the context of each story in order to situate them in the larger context of a clinical setting. Demographic data about the interviewee's teaching and nursing experience was collected at the beginning of the interview.

Interviews with open-ended questions allowed for exploration of what is significant to the interviewee. The flexibility in the interview structure allowed deeper explorations of some themes as they become apparent with each participant. By asking faculty to describe their experience of a disjuncture, I heard thick descriptions of disjunctures. I was aware that interviews are two-way social interactions and my verbal and non-verbal responses might have affected the interviewees. However, I found that the collection of narratives was more one-way and I purposefully limited my interactions to prevent influencing the participants. The interviewees shared their stories of disjuncture unhesitatingly and oftentimes with much emotion.

I then reviewed all of the transcripts and identified some initial themes (for more detail on my analytic process, see the next section). These initial themes were navigating

conflicts, dual consciousness, role modeling, and relationship building with staff and patient advocacy. Once the themes were identified, I offered to send all participants their transcribed interviews; eight participants indicated that they wanted their transcripts. All of these eight participants confirmed that the transcripts reflected what they had said in their interviews. Of those eight, four participants agreed to be in a focus group and three others agreed to discuss the themes on a one-to-one basis by phone. I was unable to arrange a convenient time with the eighth person. I called the three participants that agreed to discuss the themes on an individual basis at a pre-arranged convenient time. They were in agreement with the selection of themes from the transcripts. One focus group of four people was formed from the participants who chose to review their transcript. Focus group participants were asked to generate what lessons can be learned from these narratives concerning the best response to make in difficult situations, and how these moments could be adapted into teachable moments for nursing students. These activities could be added to nursing curricula so as to assist graduate nurses to move more successfully within the politics of health care provision as they negotiate the practice-education disjuncture.

3.7 Analysis

Maxwell (2005) states that in qualitative research there are two types of analysis: breaking down the data into predetermined categories and looking for similarities or looking for relationships between the pieces of texts that connect to create a coherent whole. I am looking for the latter, that is to say, the relationships between the texts to create a coherent whole. The research that I carried out was to explore and to understand an experience of a particular group of people, nursing faculty, each carrying out the same role

in particular care settings. My research questions are process questions rather than variance questions.

I have organized my analysis into three chapters. First, I present a thematic analysis of the experience of practice-education disjunctures. Secondly, I conduct a thematic analysis of how nurse faculty members negotiate disjunctures. Finally, I present a more theoretical analysis informed by institutional ethnography. There are two levels of data and data collection involved in the process of institutional ethnography. The first level is the individual account of an everyday experience while the second level of data is where the explication of ruling relations happens (Campbell & Gregor, 2008). *“Learning how people’s lives are organized outside their own knowledge and control makes it possible to understand domination and subordination”* (Campbell & Gregor, 2008, p. 61). The researcher needs to find out the missing organizational details of how the broader setting is actually coordinating the local activities. To do this, I will look at the varied texts organizing nursing practice in Chapter 6.

Coding Process

After the initial review of the transcriptions I then coded the interviews using MAXQDA software. Where the verbatim transcripts identified specific people or places, I replaced those with initials or a general description. For example, instead of a name of a hospital, I replaced it with ‘hospital’ as a generic term. In my initial coding, I identified the prevalent conflicts due to disjunctures. These conflicts were impacted by the dual role of faculty, relationship building efforts of faculty, the faculty’s responsibility for role modeling, the desire for patient advocacy and the efficiency model directing the functioning of the health care system. I will discuss these in more detail in the next chapter.

The coding that I initially used with the MAXQDA software was:

Green = demographic data

Blue = dual role as faculty and nurse

Yellow= role model

Magenta = strategies for curriculum and orientation of new faculty

Red=conflicts

As the narratives of the conflicts were the most numerous, I read them all over as a group and initially categorized the conflicts by who was involved:

Faculty with staff nurses

Faculty with auxiliary staff

Faculty with students

Students with staff nurses

The highest incidence of conflicts occurred between faculty and staff nurses. The fewest number of conflicts were between faculty and students, with a total of only two narratives. As I reviewed the color-coded segments about dual roles as nurse and teacher, role modeling, and conflicts, I recognized a pattern of a process of negotiating and navigating through the practice-education disjuncture. This process is described in Chapter 5.

3.8 Construction of Quality

There is a great deal of discussion in the literature about credibility of qualitative research. Tracy (2010) recommends an eight-point model to assure quality of qualitative research. These criteria are: (a) worthy topic, (b) rich rigor, (c) sincerity, (d) credibility, (e) resonance, (f) significant contribution, (g) ethics, and (h) meaningful coherence. She

suggests that researchers use these criteria in qualitative research studies to improve the quality of the study. I reflect now on how this study fits these criteria for quality.

Table 3. Tracy's (2010) Eight Criteria for Excellence in Qualitative Research

Criteria (Tracy, 2010, p. 840)	Application
Worthy Topic: relevant, timely, significant, interesting	This topic arose from my role as a nurse educator preparing nurses to work in the health care system and my personal experience of family members' encounters with the health care system. I have both a personal and professional interest. Nurses are a human resource so it is relevant that we try to make the education of nurses less traumatic. It is addressing a longstanding issue and using the results to inform nursing educators' practice and curricula.
Sincerity: self-reflexivity, transparency	This study has personal meaning for me, as I am a nurse and a faculty member in a nurse education program at a post-secondary institution. The interviewees were informed at the beginning of the interview of my "insider status." I think that it helped with the collection of stories, because I understood the "insider" terminology such as acronyms and medical terms. I chose the study because of my interest in the experience of nurse educators of the disjunctures but had no preconceived notion of what the

Criteria (Tracy, 2010, p. 840)	Application
	experience meant to individuals, although I made an assumption that it was a common and uncomfortable experience.
Credibility: thick descriptions, crystallization, multivocality, member reflections	Inviting faculty with differing levels of experience from different nursing programs, and in different clinical settings in addition to interviewing placement coordinators, enhanced the richness of the data. The narratives that were disclosed had themes in common and the experiences appeared to be similar enough to confirm that the issues were common to the nurse faculty that I interviewed. The stories that were collected about experiences of disjuncture were taken verbatim. The context in which those experiences took place were explored and used in the analysis. Dorothy Smith's institutional ethnography approach takes into account complexity and multiple perspectives. Using the narrative interview form, there were 24 participants' views of disjunctures. To address member reflections, I took my interpretation of themes to individuals and the focus group and asked them to confirm that the data collected does reflect their reality and that the interpretations are plausible. I heard back from eight of the 24 participants who agreed with my selection of themes.

Criteria (Tracy, 2010, p. 840)	Application
	The focus group allowed for participant reflections and provided an avenue for feedback and affirmation of themes.
Resonance: aesthetic representation, naturalistic generalizations, transferable findings	I presented my themes at a nursing education conference and a qualitative research conference. At the nursing education conference, the audience of 50- to 60-nurse faculty confirmed that the themes were relevant to their experience of a practice-education disjuncture. At the qualitative research conference, not all the audience was comprised of nurses but many were, and they confirmed that the themes were what they had experienced as well. I kept journal records and in the process of journaling, any insights gained from the interview data, which raised more questions were clarified by returning to the participant or in the group interview. The generalization that I make across the details of the disjunctures transfers to the larger system in which they take place and my argument is meant to address the greater “translocal” context. Smith (2005) adds that because institutional ethnography addresses translocal relations across settings (and thus findings can be applied across different locations), countering the criticism that qualitative research findings are not

Criteria (Tracy, 2010, p. 840)	Application
	generalizable and is limited to a specific particular situation.
Significant contribution: conceptual, practical, moral, methodological, heuristic	This research is practically significant because it sheds some light on a current concern of nursing faculty and outcomes of the project which have some transformative value; it has generated some actions that can be taken to advocate for patients, students and staff nurses.
Ethical: considers ethics related to procedure, situation, culture, relationships, exit	The research project received approval from UBC's Research Ethics Board. I ensured that all participants received an invitational letter with detailed information of the research project (found in Appendix B). Participants were assured that anonymity would be maintained. All participants signed an informed consent document (found in Appendix C) before the interview. When I met with individuals and the group, I requested permission to audio tape our conversation before proceeding with audiotaping, explaining that it would be transcribed verbatim but would be stored in a secure location to which I alone had access. The verbatim transcripts did contain some identifiable names and locations but I removed these and did not use anything that would compromise anonymity of the interviewee, and care was taken to protect the interviewee

Criteria (Tracy, 2010, p. 840)	Application
	<p>voices. No situations arose that suggested harm could have happened to the interviewees. I took care to establish trust and respectfully engaged with the participants to create conditions for telling as well as listening. Because the nature of the topic was sensitive for some of the participants, I addressed this by proceeding slowly in the interview and pausing when a participant needed time to collect their thoughts. I maintained a kind and supportive presence during the interview.</p>
<p>Meaningful Coherence: achieves what it purports to, uses methods and procedures fit to stated goals, interconnects literature, research questions, findings and interpretations</p>	<p>The purpose of this study was to explore how nursing faculty make meaning of their experiences of the disjuncture between what is taught about best practice in nursing schools and nursing practice found in many clinical practice sites that do not meet these standards. I did this by interviewing faculty and recording their stories/narratives about disjunctures. The literature was reviewed to understand the context in which these disjunctures take place. The analysis of the stories was carried out using an institutional ethnography perspective for examining the underlying invisible power relations and the complexity of the social world in which faculty are embedded.</p>

According to Creswell (2007) the notion of dependability should be employed in qualitative research. The main technique is to create an audit trail so that the process by which conclusions have been made is transparent to the reader. I have retained all collected data, audio taped interviews, written transcriptions and coded segments of interviews on spreadsheets. I have addressed dependability by taping interviews, transcribing these tapes carefully and storing both the tapes and the transcripts in a retrievable place. Because this study is a dissertation, my research committee will be reviewing my thesis, so in an indirect way, this could be considered an external review and audit.

3.9 Chapter Summary

In this chapter, I have described the methodology used to gather my data. I have outlined how I made use of narrative-oriented interviews and focus groups, selection criteria, recruitment strategy, procedures for analysis and matters of quality using Tracy's (2010) model. In the next three chapters, I will present a thematic analysis using the three research questions to organize the data. The first chapter of analysis (Chapter 4) is centred on the first question about the experience of disjunctures. The second chapter of analysis (Chapter 5) details how faculty navigates the disjuncture, and the third analysis chapter (Chapter 6) is an institutional ethnography approach to the narratives of disjuncture.

Chapter 4 Thematic Analysis: The Disjunctures

4.1 Introduction

This chapter outlines the findings with respect to the first research question: what meaning do individual nursing faculty members give to their experiences of the disjuncture between practice and education, that is, between what is taught about ethical and best practice in nursing and nursing practice that is found in many clinical practice sites? In this chapter, I will describe the themes arising from these narratives of disjunctures. In many respects, the overarching subject is an exploration of the problems faculty members have faced or what might be called ‘a language of critique.’ I will do a deeper analysis in the following chapters as well as address the second and third research questions and shifts in orientation towards a ‘language of possibility’ or action; that is, how participants described their navigation through these disjunctures and the implications for nursing education. A more detailed discussion of my analytic and theoretical interpretation of these narratives follows in Chapter Six.

For analytic purposes, these chapters are divided. However, there is an overlap of themes found in each chapter. For example, in the narratives in this chapter, faculty described the conflict and resulting distress, but they were also speaking about the kinds of actions they were taking in response to their distress. Thus, in each narrative excerpt, there may be multiple themes. For ease of presentation, different themes are foregrounded in each chapter.

4.2 Conflict

I asked the question, “Can you tell me about an occasion where you led a group of nursing students in a clinical experience and you found that there was a disjuncture about what had been taught as ethical and best practice at school and the actual practice found at that particular clinical agency?” This elicited almost immediate emotional responses. Some of the experiences had occurred recently while others had happened years ago but were still fresh in terms of emotional impact. The most common theme in the narratives was conflict and a feeling of tension or discomfort for faculty members. The conflicts were between faculty and staff nurses or other unit staff with the majority being between faculty and staff nurses. Only one narrative spoke of conflict between faculty and student. Was this due to the power imbalance between faculty and student where students feared challenging the faculty? Faculty reported that students were conflicted internally because they would receive opposing messages from faculty and staff and hence were afraid to speak up to the staff. I categorized the conflicts around the issues that created the conflict. The majority of conflicts related to implementation of nursing procedures that were different than what was being taught at schools. The second kind of conflict related to patient advocacy where faculty and students would advocate for patients, which brought them into conflict with the staff. Sets of conflicts were related to notable uncomfortable moments where power imbalance was central to the story. The hidden hegemonic practices that are present in clinical settings were underlying these narratives. What was unsaid is interesting to note, with the exception of one narrative about nurses not speaking English, there was no specific mention of race as an issue within a practice education disjuncture.

4.2.1 Narratives of Conflict

Incorrect Nursing Procedures

These conflicts related to staff nurses' implementation of nursing procedures that were different from those taught by schools. There were 16 narratives of incorrect medication administration from the 24 faculty interviewed. A recurring theme in these medication-related conflicts was with the staff nurses not ensuring rigorous medication administration processes. Medication administration is taught in school as a process that prevents errors. An Institute of Medicine (IOM) study of patient safety in 2000 found that 96% of such errors were preventable. Nurses act as gatekeepers and protect the patient from medication errors made by doctors or pharmacists. However, nurses' medication administration has few safeguards simply because it is the end of process. That is to say, a physician can prescribe a medication, and then a pharmacist and a nurse will check that order. The pharmacist can fill the prescription and a nurse will check that, but when a nurse goes to administer the medication, there is only that nurse to catch any errors. In 2005, 19% of hospital RNs reported medication errors in the past year (Shields 2006). This explains why schools teach students to do many safety-related checks during the process of medication administration. Many times staff nurses are not demonstrating these safety checks as they are pouring or giving the medications. Faculty members would intervene if there were visible errors, such as leaving medications at the bedside if the patient was unable to take them at the moment that it was offered.

In the following two incidents, the instructors pointed out to their students that leaving the medications on the bedside table was an unsafe practice.

Faculty #13: ...*We see people pour their meds and lock them up in the med cart or leave them at the bedside...I tell students, if I ever find you doing that, I will haunt you for the next seven generations. You do not do that because you do not know what will happen to those meds if you are not looking at them ...It's just too easy for somebody to make a mistake. A bedside table gets pushed over to the wrong bed and there you go... the staff nurse walked in at the time and said why can't you give them and I said we can't, they're just sitting at the bedside...after the nurse left I said, I would throw those meds in the garbage... nobody now can identify with clarity what these meds are. I thought the nurse had gone but she was still in the area just on the other side of the curtain. Then the nurse came to me in the hallway later and said, don't insult my practice I know it's wrong but we're busy. I said that I'm teaching a student and they have to learn best practice*

In the preceding scenario, the staff nurse acknowledged that the practice of leaving meds instead of having patients take them as the nurse stands there is wrong, but excuses the practice because she is too busy to wait while patients take their medications. The nurse not only defended her behaviour but also was angry about having to do so and took a hostile stance with the faculty member.

Faculty# 9: ...*The meds had to be crushed and given in apple sauce. The patient was dysphasic so it was a bit of an ordeal for the nurse who was busy and it seemed quite nice that the student could just sit at the bedside and feed the patient and the student came to me and said can I give these meds to this patient? I said did you pour the meds? She said no. I said what do you know about administering medications that would apply to this situation? She said well I probably shouldn't give them. Exactly*

I said. So she didn't give them. But she was too afraid to go to the RN and say that she couldn't so I went to the nurse and said the student can't give these meds because it's not her patient and she didn't pour the meds. The nurse looked at me rather guiltily and said I kind of thought she couldn't but I thought I'd take a chance which is dreadful, but...

In this scenario, there is another break in proper medication administration procedure. Again the staff nurse knew that it was not safe practice to ask a nurse to give a medication that someone else had prepared, but asked the student anyway. The student was too afraid of the staff nurse to refuse the request so went to her instructor for support to refuse the request. Other medication administration problems identified by faculty and/or students were medications being drawn up ahead of time, improper technique of holding an infant and of cleaning an area for immunization, and not questioning a medication dosage that was outside of normal parameters. What is being taught in schools was not practiced, and conflicts arose when the instructor tried to maintain best practices while the staff nurses advised students to do things differently. In these preceding scenarios, the staff nurses admitted that they were using unsafe procedures after being confronted by faculty. The students were placed in uncomfortable conflicted positions, because they were afraid to refuse the request yet realized that they were not using best practice. They needed the faculty support to refuse the request. The student's fear of standing up to the staff nurse is a sign of the hierarchies inherent in the practice setting.

Other nursing procedures that led to conflicts were non-compliance with sterile conditions, use of out-dated treatment for hypoglycemia, use of out-dated dressing procedures, supplementing newborn feeding with formula when it was not indicated, unsafe

suctioning procedure, physical abuse of a patient, improper monitoring of oxygen saturation and poor assessments. In the following narrative, faculty described how staff were upset that students had set the alarms on the tube-feeding pump that ensured the most accuracy in measurement of the feed. The staff felt that the alarms were disruptive.

Faculty #4: ...Complaints from a pediatric unit went to my supervisor at the university...that is, I was confusing the nurses because with the kids on a feeding tube, they wouldn't program the pump with volume or measure out the feed, they just haphazardly dump in what they think is the right amount of feed, where I was teaching the students you need to program the pumps to beep when the feed is done but the nurses on the floor didn't know how to reset it. So, we even went so far as to, when we were done for the day, set it back down where the nurses had it before to make them happy but apparently, we were too disruptive. ...

In the next narrative, the staff nurse is using an incorrect procedure and in doing so depriving the patient of the full dose of morphine as ordered by the doctor. The student seeks the faculty out to help champion for the correct procedure.

Faculty # 5: ...But this nurse, would you believe that she was flushing with saline? ...that was an absolute boo-boo...so when my student came to me, I said you need to go online to see the protocol. I went to the nurse, with the student, and showed her where it said not to flush and somehow she couldn't get her head around it. So, I told her that I would talk with her clinical educator...she was not very receptive to that idea...

The staff nurse did not believe the student or faculty so the faculty nurse sought out the clinical educator, who was appalled that the staff nurse was making such an error, and thanked the faculty and student for pointing this out.

Sometimes, instituting best practice was more complicated than expected. An example was with the administration of an intramuscular injection of an antipsychotic medication.

Faculty # 18: *...In regards to the IM injections...the students were only taught about the ventral gluteal injection site, because it's considered the safest. Whereas in practice, in the mental health units that I have the students on, they were often using the dorsal gluteal site...*

This incident demonstrates the complexity of negotiation and decision-making that a nurse faculty encounters regularly. The dorsal gluteal injection site used to be taught as a site for intramuscular injections but it is no longer taught because of the risks involved in using the site. However, as this particular medication is used for a chronic condition, most of the patients arriving for their injections, expected it to be given at the dorsal gluteal site and due to the risk of non-compliance if the site was to be changed, staff nurses were using the dorsal gluteal site. This caused great consternation amongst the students and faculty because they were unsure how to proceed. They researched as they had been taught and found that the texts and the hospital policy indicated that the dorsal gluteal site was not to be used, yet it had to be weighed against a non-compliance issue if the patient was resistant to having the medication given in another way. A component of the chronic psychiatric illness is paranoia so it was important to maintain the patients' trust. The instructor had to decide whether to allow the student to give the medication, even though the site was contraindicated by hospital

policy, because all the staff nurses were continuing to use the dorsal gluteal site as patients expected.

Also adding to the confusion was the drug information brochure that initially said it could be given at the dorsal gluteal injection site and then in another rendition of the flyer, stated that it was not to be given by dorsal gluteal injection. The instructor had to discuss the situation with several people and in the end, decided not to allow students to give the injection (as unlike the staff nurses, these students had never used that site so had no experience with dorsal gluteal injections and there was an additional risk of unpredictable or combative patients).

Patient Advocacy

Faculty and/or students advocating for the patient created friction with staff nurses and other health care providers on the unit. Advocacy for patients and their families is taught in schools but students see staff nurses and other health care providers, such as care aides, working in a way that they saw as efficient but that sometimes seemed to overlook patient needs. Patients' needs were subordinated to needs of organization. The need for expediency also had a part in the incorrect nursing procedures because shortcuts were necessarily taken to complete the work.

One narrative was about a difficult situation in which there was an agreement with the staff on the unit to allow smoking in exchange for medication compliance. Students were concerned about the hazards of smoking but also wanted to support the patients and staff. This was not a clear-cut safety issue but more about the ethical issue of bargaining for medication compliance and encouraging smoking that has an impact on health.

Faculty # 3: ...*They (students) had to give cigarettes out to psychiatric patients in order for them to take their meds...the students were comparing their clinical sites, and some places were not doing that, and other places were, and, and they had brought in an ethicist to discuss... it was such a kerfuffle for the students. They were having a really hard time with that...*

In this narrative, an instructor was in conflict with a staff nurse in advocating for better evidence-based care.

Faculty # 4: ...*There were twin boys, five years old who were in with a flare-up of asthma and pneumonia. They were getting Ventolin every hour and had oxygen by facemask on but they weren't on the oxygen saturation machine... I had two students in the room, one on each patient, and the supervising RN decided that she was going to try to wean the oxygen to see how they'd do...so my question was, "How do you know how they're doing? The supervising nurse responded that if they needed more oxygen they would turn blue, breathe faster and show that they're needing intervention. I replied, 'How do you even have a baseline of where they're starting if you're not measuring oxygen saturation?' ...You're giving these kids Ventolin every hour, and they're requiring oxygen by mask, they're sick kids." I said, 'So, I'm not sure that I feel comfortable with what you're doing, and for the purposes of my students learning, I'm going to ask them to put the oxygen saturation monitor on the kids, and we'll see how it goes.' ...She gave me the whatever kind of look and walked off. I talked with my students about what they saw and what they thought, and they said that they were wondering why they weren't on a monitor, but they didn't want to say anything because they didn't want to step on anybody's toes. To which I told*

them, 'I'm teaching you to practice to the highest standards.' I said, "Sometimes you may see something that you don't completely agree with but you need to remember that it's the patient's safety that is the most important thing. That's why you're here. So, sometimes you may need to step on somebody's toes to keep your patients safe'...

Students are reluctant to “step on toes” because they fear that the staff nurses may give negative feedback about their performance to the instructor. They are in a less powerful and potentially vulnerable position. The instructors are aware of this and role model advocating for best practice for future use by a new graduate. The students’ fear again expresses their struggle to act within hierarchies.

In another narrative, a student was advocating for a change in medication to attain better nausea control and the instructor encouraged the student to advocate for his patient. In this scenario, the student’s initial request for a change in medication was refused. Because the student felt strongly about advocating for a change in medication, he sought out his instructor and explained what was happening and the instructor encouraged him to go back and try again. The student was successful in negotiating the change because he presented the evidence from his research with the instructor’s support and encouragement. Advocating for the patient created tension for the student because the staff nurse had initially refused the student’s request and this student was afraid to remake a request again, highlighting once again the struggle to act within hierarchies. However, the student persevered because the faculty supported the evidence-based practice. By supporting the student to try again, faculty is affirming the importance of patient advocacy.

Faculty # 5: ...So my student has this patient...The patient is so nauseated, he's puking his guts out, and the nurse told the student to give Gravol 25 mg IV and so the

student came to me and said I talked to my nurse about the Gravol not working... The student states that he has done some research ...and from his research, Ondansetron would work better. So I said, 'Why didn't you tell your nurse that?' 'I did, but my nurse said, 'Oh no, I prefer Gravol, we should stick to what you know, the least amount is always best.' So I said, 'Ok, so you're telling me you did research, and you found out that you are feeling strongly about this Ondansetron medication, so, what's wrong with you arguing with your nurse? ... Today's a new day. This is a nice nurse. I think it's worth a shot at advocating, you can present it in many ways... So all those good reasons you read in your pharmacology text tell the nurse and see what happens...if the nurse says no, let's give Gravol, ... come back to me.' And it worked beautifully. That nurse agreed with the student's assessment, and they gave Ondansetron and it worked better. My student was in seventh heaven. And so was I because he did advocate for that patient...

There were also a few narratives about elderly patients in residential care. These conflicts were with care aides and not nurses. In residential care, unregulated care providers supply most of the basic care for the residents. They far outnumber nurses and although the nurses have the power as managers or clinicians, the unregulated health care providers often appear to have power.

Faculty #9: ...There was an incident where a senior was left the entire night in soiled linens and Attends and the healthcare provider indicating that it would be best to leave that person in that state until their bath at 10:00 in the morning which generally didn't happen until noon. So the students found it really difficult when they did speak up and say no, we should be changing this person now. They were very

abruptly reminded that they were just students, just students, the word “just.” When the students informed me of what happened, we went in and changed the bedding and the clothing. I did discuss it with the healthcare provider and I have to say the reception of me approaching that conversation was not met very well. The non-verbals surrounding what are nurses, what are nursing students here for anyway if they can’t follow orders and those kinds of comments that I believe were demeaning. They felt demeaning to the students...

The following is another conflict with a care aide ...

Faculty #9: ...So my plan was to have the student partner with the patient every Thursday when we came in so the care aides would know that some of the aspects of care would be looked after by the students. So when I left the room, the student remained with the patient and they were having quite an engaged conversation about her kitty cat at home, and the care aide came back and said to the student, you should leave her alone now, you’re just going to cause her more problems and then looked at the client and said, you’ve become quite a problem, you’re just an attention seeker now. And so that upset the student and the client said, well I don’t believe that, I want the student to stay. When I heard that, it seemed to me to be escalating so I walked back and asked if there was something that needed to be clarified following the conversation we had just had at which point the care aide just turned and walked out of the room looking quite angry. So I took that to the resident care manager and the resident care director just indicating what had happened, and that I had concerns about what would happen after the student left, given the interaction that I’d witnessed between the care aide and the resident. And on the second occasion, when

we went back the next week, the same care aide reprimanded the student again when she was in assisting with breakfast. So the care aide brought the tray in and set it down and just left it and the student proceeded to help her and the care aide reprimanded her for assisting her...

In the follow-up, the instructor found out that there had been several complaints about this care aide and the care aide was let go. The care aide might have been responding to her positioning as an unregulated health care provider in the hierarchical structure in the health care facility. Even though she used the term ‘just’ to describe the students, nurses are still located in higher positions on the hierarchy. Furthermore, she might have been afraid that if students are giving this kind of one-on-one attention that she could not give because of constraints of workload, there may be an expectation from patients when the students leave to provide this attention.

Icy Climate and Moral Distress

The following narratives were situations that faculty members shared with me about situations that are meaningful to them. They were not conflicts about nursing procedures but situations that they recalled as disjunctures and left them with residual discomfort.

Underlying power issues are present in these stories.

There were narratives in which students were made to feel unwelcome.

Faculty # 10: *...As an instructor, I find it very difficult sometimes because we have some nurses who are very willing and wanting to help and you have other nurses who don't want too much at all to do with the students. So I try to talk with the students about recognizing that and if they are feeling a nurse is not being open with them or is eager to have them, to talk to me about it. ...*

Other narratives also spoke of the friction or lack of trust between staff nurses and faculty or students. This following incident happened several years ago but the faculty member was still distressed by this because she felt that there could have been a better outcome if the staff nurse had trusted her and called a doctor. In this situation, faculty and student answered a call bell, saw a patient in distress, did what they could and reported to the staff nurse in charge that she should call a doctor. The staff nurse did not call a doctor and the patient's condition deteriorated and he died.

Faculty # 8...This nurse did not have to believe me that the patient was passing out and there is a problem...Was it ethical to leave this just because the nurse was busy, could the nurse delegate this to someone else, were we really promoting this client's health, was this caring, was this justice, was this best interest of client? ... Someone who was not yet diagnosed, never been sick in his life and then is dead...

In the next narrative, the communication problem is a case of how staff nurses were not using English in their communication with each other. The instructor noted that staff nurses were speaking to each other in another language in report and then over a patient and the instructor reported this to the unit manager.

Faculty #10: ...We had a placement where there was very bad staff morale and the staff were always fighting with each other and part of it had an ethnic aspect to it where they spoke a certain language and they would only talk to each other. And they would ignore the student nurses; they actually ignored anybody who didn't speak their language. And it ended up in very poor care for the patients. So faculty didn't want to go there, it was very bad...

The school ended up leaving the placement because care was poor and students were not treated respectfully. This is a difficult decision for the faculty in schools to make because they must weigh the need for a relevant practice setting for teaching students and bumping up against a situation in which there is constant poor practice with few good role models. Faculty members were also personally conflicted because they felt an ethical obligation to champion best practices and to stay to try to improve care for patients.

This following narrative is about the frustration of the faculty and student in their inability to access an interpreter for the patient. Student and instructor were unable to get an interpreter for the patient so communication with the patient was difficult. This was distressing for faculty and students because they could not do an accurate assessment of the patient's condition and help manage her pain.

Faculty #11: *...The patient was unable to communicate on her own, no one was able to understand her, there was a complete language barrier, and this was for daily nursing care. Do you have any pain, do you have any nausea, that sort of thing. So when the physician came, there was a friend who would interpret, but then it became a question...was the friend the right person to be interpreting for this very intimate intervention or any intervention. So the student wanted an interpreter for her assessment, this is what I thought the nurses should have, the interpreter for every assessment. But the student and I were blocked at every turn...it was really upsetting for the student...it was a ward that had a lot of change and staffing issues as well as new manager...*

This scenario points to the contextual constraints of lack of funding for interpreting services because well as an unwelcoming climate because the faculty members states that she was “blocked at every turn.”

In another narrative, an instructor noticed that one of the staff nurses gave the narcotic keys to a student, which is not allowed. This scenario upset her at the time because the staff nurse was dismissive of the boundaries of the student role and not respectful to either faculty or students.

Faculty # 19: ... I came around the corner and saw one of my students at the narcotic medication cabinet just as the RN who was teamed up with the student was throwing the narcotic keys and he caught them... And I said what are you doing? The nurse said, oh, I just gave your student the keys. I looked at the student and I said, you can't have narcotic keys. I went to the nurse and I said explicitly they can't have narcotic keys, these are students...they're not bonded, they're not licensed, what would happen if the student signed out 10 mgs of morphine under your name? ...The staff nurse said, oh, it doesn't matter and walked away...

These preceding moments of discomfort were moments of moral distress. Faculty members and students were unable to provide care that met professional standards because of their guest status undermined by the existing hierarchy. In these narratives of conflict, faculty members and/or students experienced moral distress. These uncomfortable moments were particular times of vulnerability. How the conflict was handled differed depending on the negotiating skill of the faculty and the context in which the experience took place.

Experienced faculty members tried to address the power imbalance explicitly while others did not address the power imbalance explicitly but handled the situation with implicit

understanding of the relationship between staff and students. The prevalence of conflicts is telling of the difficulties faced by nurse faculty in clinical experiences. Negative and unsupportive climates are found in hospital settings as staff nurses work with structural constraints and an increasingly complex patient care workload.

It is interesting to note that the faculty in community public health settings were the least likely to have a multitude of disjunctures while those in acute care hospital settings readily described multiple incidents of disjuncture. This may be due to increased autonomy in the nursing role in the community setting and also to different staffing models with fewer care aides and practical nurses caring for patients. In the hospital setting, the incidents were primarily conflicts with staff nurses, while in community settings the conflicts were sometimes with non-nurse team members. The conflicts with other unregulated health care providers happened only in the long-term residential care setting because this setting uses more unregulated health care providers than other settings.

4.3 Dual Consciousness: Nurse and Teacher

Faculty members are both nurses and teachers at the same time with priorities to patients and students operating simultaneously and creating tensions for the nurse faculty, a dynamic captured by the theme of dual consciousness.

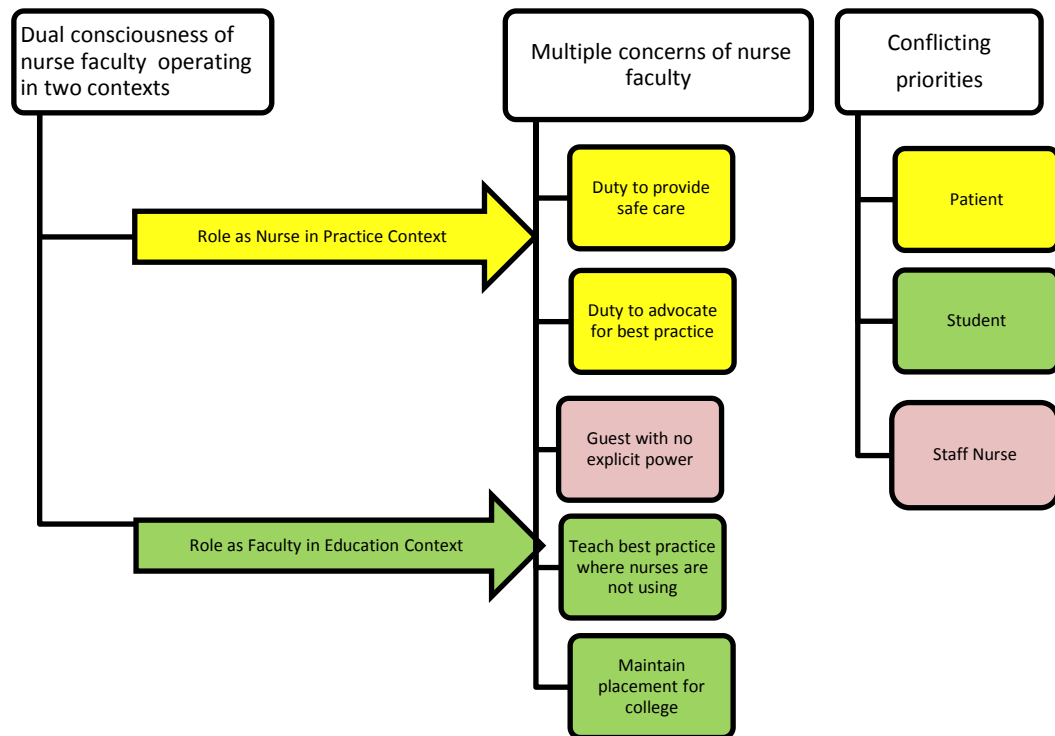


Figure 1. Dual Consciousness

The above diagram sums up the dual consciousness of the nurse faculty who participated in this study. As registered nurses, they have an obligation to their regulatory body to meet professional standards and code of ethics guidelines while teaching student nurses. As nurses, their first priority is safety and care of the patient. As faculty, their priority is the student. The conflicting priorities, the realities of time constraints and the cultures of their two worlds – practice and teaching – creates situations in which the faculty member faces pressures from both care and education organizations.

Faculty and student behaviours are constructed by organizational and hegemonic forces at play in the clinical area, but these forces are hidden. While at times, faculty members narrate that they are making a choice of patient over student, but it is actually more complex than that. In this following narrative, the faculty member is not really choosing the

patient over the student but rather choosing to teach by role modeling good practice. The faculty members acknowledge the conflicting priorities and accommodate them in a way that does not jeopardize patient safety or student learning.

Faculty #4: ...My first obligation to my work is always to the patient first...I'm employed by a college, but when it comes to my role, you can expect that when it comes to ensuring safe confident practice, my obligation is not to you as a student but to your patient...and I explain that to them, that's why if I see something that's going on, even in front of the patient, I'm going to intervene...in a way that's respectful of you, but I am going to intervene to make sure that the practice is changed. So no, my first obligation is my duty to competent practice to the patients...

Faculty # 21: ...But I always was very clear from the very beginning that the patient has to nose out, edge out my responsibility to the student. So if it was just an untenable situation for the patient, I stepped in and the students learned an awful lot by watching you do, not by what you say or not by what you push them to do....

Faculty members are not choosing between students and patients, rather, they are committed to meeting their ethical obligations regarding the public good. Students witnessing faculty members' response to this obligation are learning important lessons. Taking action to ensure patient safety is part of the faculty members' role as educators. Within the narratives the regulating texts are apparent in the comments of having to choose the patient over the student. The faculty, as nurses, are operating within the regulatory discourse that identifies their responsibilities of having to protect the public; faculty spoke about this duty to public safety as they explained their actions where they attempted to both protect the patient and educate the student. In these narratives, the nurse faculty spoke of prioritizing the safety of

the patient but also about their commitment to the students. Sometimes the dual consciousness of nurse and faculty are in conflict and faculty members feel that although they are obligated to both patients and students, they must choose only one. Faculty describe making a choice between the student and the patient but do not mention the impact of the wider health care system. They describe a narrow choice between two objects without specifying the contextual restraints or opportunities. They did speak about how they attempt to teach students about patient safety being a priority.

Nurse faculty are in two contexts: practice and education. In the education context, the teacher has control, for example, in teaching a nursing procedure in a lab. The education context has conditions that support students and their learning needs and the interactions are student-to-teacher or student-to-student. The practice context is much more complex with unpredictable situations. Adding to the challenges within the practice context are the patient and staff nurse interactions with each other and with the students and faculty.

4.4 Faculty Balancing Act as Guests

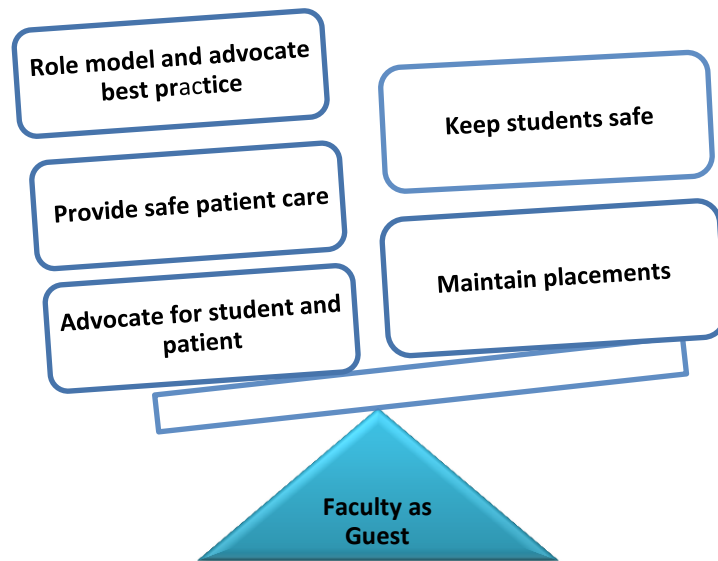


Figure 2. Balancing Act as Guest

Another theme in the clinical setting is that of faculty members as guests in the facility. Underlying this theme is again, hierarchical issues found in clinical units. Many faculty members referred to feeling that as guests, they could not speak up. Faculty felt that they were resigned to a powerless role, because they are outsiders in the clinical setting. Another instructor stated that as guests of the hospital, they had no way to enforce best practice and it was difficult to be in these situations.

Faculty # 5: *...We're guests on the unit, so that is a huge issue, because some nurses are happy with my students, but some nurses are unhappy with them for reasons that I feel are inadequate because the student is in a learning mode...sometimes I just find staff nurses' expectations are way too high and sometimes way too low...but we're guests...*

Faculty #4: *...I think... sometimes the most frustrating thing is being at that in-between place trying to make everybody happy, and try to remember what your role is that day...*

Faculty #2: *...And as instructors we have to balance how we address some of these issues because we are visitors on the units. So if something has been done that is unsafe or, I think is going to lead to a problem, I address it. If I don't see it that way, then I would talk to the students about ensuring best practice, to continue practicing how they've been taught in school because that is the current research...*

Another faculty found that because she had worked at cultivating relationships, the visitor role was manageable:

Faculty # 6: *...I think that's something to keep in mind, just remember that I'm a visitor ... Never say, this must be done. I always said to them, ultimately, you are still in charge...you are the ones who make the final decision...a lot of time because I have had a good rapport with the staff, I would say 85% of the time, they will listen to what I have to say...*

Another instructor pointed out that holistic assessment is taught, but hospitals use a more efficient and shorter head-to-toe assessment. The ideal way to practice is taught in school but not used in practice because of time constraints. This creates another tension because students then surmise that teachers at the schools are not current. Students want to do what the staff nurses are doing. This instructor's approach was to convince the students that there could be two different, but correct, ways. Faculty #15: *...I do a fair amount of bridging and being diplomatic and the bottom line is, is it safe?...*

Faculty spoke about why they had chosen to shift the focus of their practice from health care services to the educational context.

Faculty # 12: *...And I do think that's part of the reason I went into education because I thought, I can change my practice, but it's not going to change anything. But if you go in and you change curriculum and you change a cohort of graduating students' practice, then eventually, practice will change... I do believe we can change that practice. My other hope is because it's the beginning of their nursing school and their nursing career, they need to learn to integrate best practice from the start so that it's seamless and intuitive as they continue on the program. Every single time they give meds, they check a wristband for the rest of their life because that's just the way they learned...*

The following faculty relishes the opportunity of a teaching moment for staff nurses and a possibility of improving practice.

Faculty # 16: ... I'm always disappointed when I hear from a student, or witness myself, poor practice. So those would be some initial feelings although it isn't so much a feeling, but maybe anticipation that it presents an opportunity to influence both the student and perhaps the staff members. So excitement, the feeling that comes from recognizing an opportunity to act according to my role...

Other faculty wondered why practice had not changed for the better.

Faculty #13: ...We try and prepare students the best we can but once they get out there, their role models aren't the best and those are the people that they idolize. And those people shrug and say, oh you don't need to go the lab test, don't worry about this, it's okay, don't worry about the urine output, they'll be fine, they're going to get better and go home. We educated those people too and by now, with all of the education that we've all done and all the nurses we've put out there, we should've hit enough of a critical mass to have made a difference and we're not. So there's something out there that's more powerful than we are and I don't know what it is.

This statement articulates the hidden ruling relations that will be discussed in the next chapter.

4.5 Do Not Lose the Placement

Another theme was one of having to tolerate poor practice because of the lack of clinical placements and the fear of losing a clinical placement. Tension arose when faculty felt obligated to act in the presence of poor practice by their consciousness as a registered

nurse yet they were aware that the clinical placement might be jeopardized. Some faculty stated that they would try to help the facility provide better care, while other faculty would refuse to use this type of placement. If nurse faculty made a decision to follow-up on poor practice issues, they would report the incident to the immediate supervisor and then to their school placement coordinator. In one narrative, faculty stated that although students and instructor were appalled at the care in one facility, they could not act on their concerns because the program needed the placement. Faculty #24: *"I was careful, we talked about the standards and we reviewed options of how to handle the situation... and I didn't bother to fill them in on all my thinking was to protect the placement."*

Faculty members felt pressured to maintain the placement even if it was creating difficulties; the serious shortage of placements has created a situation in which units with poor practice or uncivil staff nurses have to be utilized. As nurses, faculty members were practical and created "work arounds" in situations where poor practice prevailed but there was no other placement. In these situations, sometimes the placement coordinators try to improve the unit by deliberately building relationships between the school and the unit by sending the same clinical instructor back to the same units so they might become part of team and thus, able to provide some input to improving the practice on the unit. One of the placement coordinators interviewed stated that she sees the uncivil behaviour of some staff nurses as a system problem that has been produced by a situation in which there is an unfortunate combination of stressors. Staff nurses are assigned patients with increasingly more complex illnesses but staffing is with part-time nurses as a cost-saving measure by the employer. The situation makes the nurses on the unit tense and challenged to handle any additional responsibilities such as students or faculty.

Faculty #7: *...And placements are so hard to access ...I really think that's an issue because unless poor practice is really blatant and extremely serious, some people aren't going to come forward to address poor practice issues because the unit may just say, 'Okay, ...we're not taking this group next term, we're taking another group' I mean, we don't have enough placements for our students now, so, everyone's walking on eggs...*

The faculty spoke of the frustrations of grappling with how to negotiate and to create change to fix the disjuncture because of the concerns related to loss of placements.

Faculty # 13: *...I decide (what to do) solely on the basis of my relationship with the clinical educator (hospital staff) and whether or not it's going to affect our placement and as crass as that is, it truly is a focus. So if I think I'm going to jeopardize our placement, and that doesn't mean that I don't interfere subtly in my own quiet little way, sometimes. But it also means that sometimes, what I've done is if I see really poor care, I've taken the student aside and I've said what's going on in that room is really wrong and here's why I think it's wrong and I don't think you should look after this client today, we'll find you another assignment and I will tell the nurse. So I have done that because, these individuals are ensconced in this practice and this is what they're going to do all well and fine, but then you don't have to participate...*

4.6 Chapter Summary

This chapter outlines the findings with respect to the first research question: how do individual nursing faculty members describe their experiences of disjunctures between practice and education, between what is taught about ethical and best practice in nursing and

nursing practice that is found in many clinical practice sites. The themes that arose from the narratives were of conflicts, dual consciousness, balancing act as guests in clinical areas and maintaining placements. Conflicts with staff arose when there were incorrect procedures or when faculty or students advocated for patients. Nursing faculty experienced inner tension related to the two roles they played as a nurse and educator within two contexts: practice and education. As nurses they act within a hospital practice context and as educators, they act within an educational institution context. In the educational setting, faculty teach student nurses the ideal way to care for people but then must bring these same students into an imperfect world of practice. As educators they must role model competent ethical care in chaotic areas. If workplace conditions do not allow good practice, then there is moral distress as best practice is not possible. Faculty as guests cannot speak up without some consequence. Some faculty were resigned to a less powerful role because they were outsiders in the clinical setting. However, some faculty worked with this notion of being a guest; they said it gave them more freedom to approach staff about poor practices than if they had been part of the team.

Students and some faculty, because of their perceived powerless positions did go along with poor practice. Conversely, some faculty felt obligated to stay to try to role model good practice. In the background, there was pressure from other faculty members not to create any problems because clinical placements are difficult to obtain.

Underlying all of these themes were power issues perpetuated in clinical units. In the next chapter, I will explore the narratives related to how faculty navigate through disjunctures.

Chapter 5 Navigating the Education-Practice Disjuncture

In this chapter I explore the second and third research questions of my research project. The first part of the chapter includes narratives that respond to the second question: how do individual nursing faculty members navigate the disjuncture between practice and education? Participants described the actions they took in the face of poor practice and staff who were resistant to faculty feedback. As mentioned previously, there is much overlap in these thematic categories. Although this chapter focuses on actions taken, the preceding narratives also illustrated the kinds of actions faculty were taking in response to their distress. In this section, I will bring to the fore the themes of navigating strategically through the disjunctures using role modeling and cultivating relationships with staff.

The second part of this chapter addresses the third question: how can these stories contribute to nursing curriculum and the preparation of nurses as advocates for change within the health care system?

5.1 Navigating Strategically

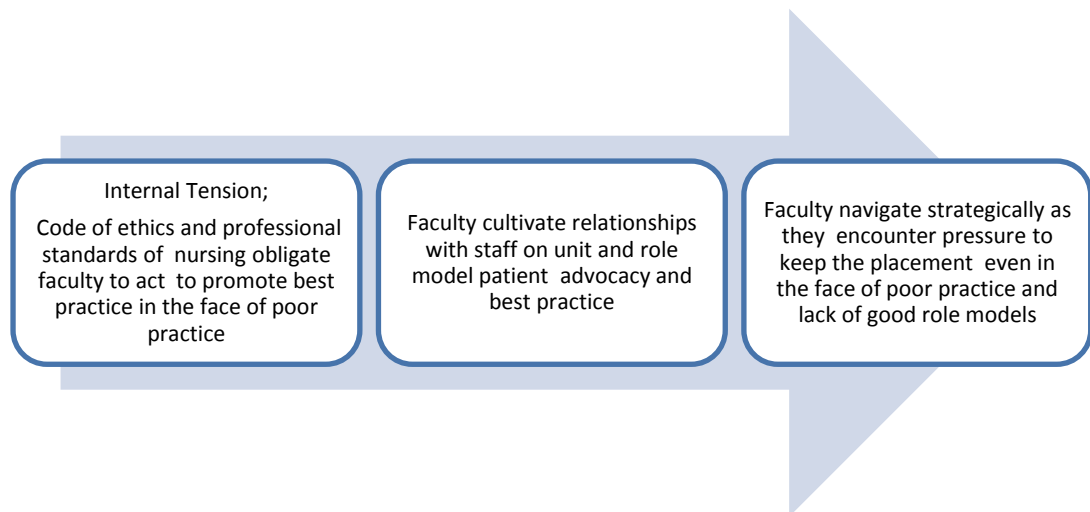


Figure 3. Navigating the Practice-Education Disjuncture

Many faculty members in the study recognized the challenges they faced as guests with little institutional power. Several described how they engaged in an inquiry process that encouraged reflective practice by the students. The nurse faculty members spoke about juggling multiple needs including the need to act ethically as a nurse — advocating for the patient, role modeling best practice, and acting in such a way as to retain the placement for future students. Others mentioned advocating for patients as a priority that would always take precedence over everything else. But other faculty members saw advocating for patients as part of the navigating process that had to take place in order to maintain the relationship between faculty/students and staff. The negotiations that were implemented had to exemplify best practice but preserve the relationship. Sometimes faculty simply said to staff, “How about if I do it?” There was a consensus that they would try to use a bad experience as a learning experience. Many used disjunctures as a teaching moment of “what not to do.”

Faculty described the complex thought processes involved in teaching students about managing disjunctures. This following narrative is about how faculty assess students’ abilities and the time and space available to navigate and to advocate, particularly with respect to different approaches to pain management. Students are taught that pain is owned by the patient and that it is whatever level that patient says it is, whereas in practice, many staff nurses use their own judgment of the patient’s pain level.

Faculty # 14: ...At a very early stage of the student’s educational experience, I concentrate on how much could the student cope with at this point in time. If they were so overwhelmed with their own responsibilities, it would be...I’ll handle it and a discussion afterwards or, if there was time and space to discuss, what they thought the possible options might be, with me suggesting a few more because I would have a

larger perspective and asking them to pick what they think would be the next best thing to do and trying to move them along. So you're pulling them out of skill based basic assessments, intervention, to try to get them to critically think things through that are perhaps politically charged or an ethical dilemma kind of dissonance kind of thing and for some students, in the moment, that's very doable. Some of them are mature students, some of the ones that come from perhaps a background of some sort of helping or have perhaps educational human rights or whatever, are much quicker to go into understanding the global aspects of the situation and wanting to intervene and step up and recognizing that while they may not be able to have much clout, they can certainly engage in the process much more actively...as an educator, it becomes very much of what, in the moment, is going to serve the patient best and the student's learning best and move the situation forward... I'm going to take the student who is exceedingly passive, very deferential to authority and hopefully I will move them off that mark by the end of the term because pain mismanagement for them is a trigger that will cause them to space themselves and move on with those kinds of things. A lot of debriefing, so post-conference, pre-conference and to talk about why such things come up. Students are often triggered to outrage, blame, negativity, attack and so you walk several paths at that point trying not to look as if we're representing the system and defending it unconsciously, suggesting that their punitive nature really is just very similar to the punitive nature of the nurses wanting to solve the pain for the patient...

Moments of disjuncture are treated as a teaching opportunity to be navigated through with the relationship between the school of nursing and the hospital unit placement in mind.

Faculty # 16: *...I'm always disappointed with when I either hear from a student, or witness myself, poor practice...Sometimes I'm very surprised because sometimes it's poor practice or some sort of ethical violation that, does not fit with my knowledge of that particular staff member. So those would be some initial feelings also, although it isn't so much a feeling, but maybe an anticipation that it presents an opportunity to influence both the student and perhaps the staff members. So excitement, maybe. The feeling that comes from recognizing an opportunity to act in my, according with my role...*

With an incident involving a student witnessing disrespectful communication between a patient and a care aide, the faculty described how she managed the disjuncture.

Faculty # 16: *...And part of my conversations with students about any issue, is always around what are the contextuels? What's the preparation of this person, what's reasonable to expect, how do we intervene with different people at different times based on their situation, their experience, their level of preparation and so on? ...And I went out of my way to really facilitate a relationship with the care aide and to encourage the students to be really respectful and seek her out for any kinds of things that she was there to do. So not to alienate her and provide her with the respect and be aware of the fact they'd been able to model, help influence, but that that didn't mean that they were any better than her, that there'd been some learning...*

As has been discussed earlier, the idea that the faculty needed to role model and not merely evaluate or judge student behaviours came up often. In units where there was ongoing conflict with staff, faculty deliberately avoided difficult staff and chose to partner students with more supportive people. Sometimes staff nurses were chosen to partner with students

because they were good role models. The deliberate choice of a good role model exemplifies the importance of the role model-strategy. In many situations in which students came to faculty with a distressing story of disjuncture, faculty would intervene on behalf of the student in order to role model action and advocacy for patients.

Faculty described going through a deliberate decision-making process while considering the ethical issues:

Faculty # 16: ...I notice something and I think it's not the greatest, I'll just kind of keep an eye on things and I'll get a sense if this is a pattern and if it is a pattern, I will make a decision that there's something that's needed. But also, in those situations where I notice that the practice is poor or I think that the way of being with patients could be more power sharing, I'll often try to influence that in a role modeling and encouraging way rather than in a punitive way. But if I think there is a pattern and I think that it's something that's substantive, then depending on my relationship with that staff member, I'll either go directly to that staff member and have a conversation or I'll address the issue with the supervisor...

Here the faculty illustrated a process of observation and analysis, looking for patterns of poor care, and a staged approach to intervening. Initially she would role model sharing power with patients, rather than overtly criticizing the staff about the quality of care. Depending on the response, she might then discuss the care issue directly with the staff member and might proceed to contacting a supervisor.

Another faculty member spoke about the importance of post-conferences as another site where these disjunctures could be explored. Faculty # 24: *"And then in post-conference we debriefed...when I think back, the students were shocked and they were saying things like,*

I don't want to be that kind of nurse...” She discussed the situation with students pointing out that it was important to advocate for clients and how you might do that in such a way to avoid conflict with staff. The post-conference held at the end of the clinical shift was also seen as an important location of debriefing poor practice that could not be changed. In these cases, faculty also brought a reflexive inquiry approach, guiding students by asking: What might have led to this practice? Who was involved? What else was happening at the same time? Was there a shortage of staff? Was there a situation requiring more attention at the particular time? How else might it have been handled? What was the best practice in this situation? What might you do in the future faced with a similar situation?

Faculty #10: ...Sometimes a group can be very helpful. A conjoining of many stories about the same theme can bring us all to a conclusion that it's more of systems kind of thing and what could we do about it and where might we bring resources in from...

Faculty spoke about the importance of reflective journaling by students and in the next narrative, faculty describe the importance of students examining their own development as nurses and what they are observing in their practica.

Faculty #16: ...The critical piece through all of the navigation is, what kind of a nurse do you want to be? Look at who are the role models, in terms of the journaling, that last phase is always the implications for future practice, but all of it kind of dovetails into them making, realizing they have a choice. What kind of nurse is it that you're seeing, what do you think is reasonable, how do you want to be seen when you're a graduate nurse? So what kind of a nurse do you want to be?

Below, another faculty member can be seen bringing in an inquiry approach that involved bringing in evidence based research articles and using them in discussion with staff

and managers and how she collaborated with them on an outcome that resolved their differences. The conflict was whether a c-section incision should be left exposed or covered with a dressing.

Faculty # 6: ...Sometimes the nurse is so adamant of the fact that they should leave the wound exposed...I talked with the nurse, I said, "Just remember the students have learned this at the college. They know that they put something on it." So, I reminded them, this is where the students come from. Now, I think everybody is at peace with that, so we decide whether we leave it exposed or put the dressing on it. So, that was discussion with students, colleagues, Patient Care Coordinator, and looking at the available literature. So, it's a multi-pronged approach to resolve these differences in what we learn in class and clinical practice...

One of the placement coordinators spoke of having a situation in which the instructor and staff nurses were in a conflict. The staff nurse was not willing to listen to her suggestions saying, "You don't work here." The manager of the unit called the school and complained about the instructor but the coordinator backed the instructor because she had years of expertise in this area. The placement coordinator asked the hospital unit to work with the school to make practice better. In this instance, that did not work out because the relationship had not been established. This expresses the importance of establishing a relationship and an environment of trust and the balancing act that faculty have to perform on an ongoing basis. Do they speak now? Will it hurt relationships? Does the school need this placement? How much of this practice can I ethically tolerate?

5.1.1 Cultivating Relationships

The intentional management of relationships with staff on the units was a theme throughout the interviews. Relationship-building by faculty with staff was a key aspect of their practice and an important part of negotiating with the staff about disjunctures. A good working relationship with the staff nurses on the unit was perceived as critical for ensuring the best experience for their students. Faculty also felt it was important to teach and coach students about how to build relationships. For example, the students were taught not to critique staff unless it was unsafe for the patient. One of the approaches the faculty spoke about was the matter of gaining trust by being part of the unit team, even though they were guests.

Faculty # 7: ...When I was at (name of place), I was a part of the team...you initially have to build your credibility that you're a competent faculty individual, well organized and ...because I actually did the home visits, I became someone that they saw as also a competent practitioner...

Faculty #6: ...I find that if you take the role of the investigator, it isn't confrontational...some of the nurses they're like, 'Oh, ok, I guess I didn't do this part.' ...So, I try not to get too excited and to just take a low-key approach...of an investigative finding...

Faculty #4: ...Sometimes I find it difficult and I don't want to make excuses for the nurses.... I don't want to be insulting or disrespectful to the nurses in front of the students or make them think that I think less of these nurses for their practice ... I find it difficult...explaining why you're seeing the lack of good practice. Without being insulting or rude or disrespectful...

In the following narrative, during an immunization clinic, the staff nurse had not followed a procedure as the students had been taught. But the instructor had the students step back and reflect on the context. The nurse in the scenario was experienced and had run hundreds of similar clinics over a period of years. The students were able to see that they could still do what they had been taught but the staff nurse had different expertise that allowed her to practice differently but maintain safety.

Faculty #3: ...*We have a good relationship and we're teaching the students how to work in partnership, how to communicate, how to build a relationship, and so you always have to balance these things out. If it was definitely unsafe for the client, I certainly would have to say something but it wasn't. But for nursing students, we need to be a lot clearer with themthe nurse might know what to do with the adrenalin, whereas some students or a novice nurse might not. So, she's a very experienced nurse. She does a lot of immunizing, and she knows she has the adrenalin kept there...*

Because the faculty and the staff nurse had already established a good relationship, the students were allowed to carry out the procedure as they had been taught while understanding why the staff nurses were doing things differently.

The complexity of the relationship between faculty and staff nurses is reflected in the phrase, "the dance." Faculty members understand why sometimes efficiency surpasses best practice but by working on the relationship with the staff, they hope that staff nurses are reminded of the best practices and the way that they used to practice when they first were new graduates.

Faculty #12: ...*The dance between faculty member and the working relationship with staff RNs that I have to maintain... from their perspective, I am a nurse. I've worked in medicine, I know it's ridiculous to sit down and feed somebody his or her 35 meds. You've got a million other things to do, but then I have to maintain the best practice front. Sometimes it is a front because there are many times when, in some situations I might be tempted to do the same thing as a nurse, so there is a tension....I know it's absurd, but the students need to learn this way, to which they all say yes, I know, we learned that way too and now we do this. I think it's good though, because quite a few of the staff members have come to me and said, it's good that you catch us on these things because otherwise we don't think about it and it's important to have them brought to the forefront again. You know, it's just a routine day at work, if we didn't have students on this floor, we wouldn't think. So I think it's good both ways...*

5.1.2 Role Modeling

In many of the narratives, faculty were hopeful that they could change poor practice by role modeling best practice. Role modeling is an important part of the navigating through the disjunctures. Faculty would deliberately role model as a strategy in teaching students as seen in the excerpts below.

Faculty # 16: ...*I felt that these skills are quite complex and that first of all, we have to teach them. We have to encourage them, we have to be a role model, and then we have to expect that there is thoughtful reflection, that is broad in its thinking, that does incorporate that critical social thing, the context of practice, factors that are influencing and the phenomenological viewpoint...*

Faculty # 17: *...A nurse had, indeed, assaulted a patient and then it became an issue for me about what should we do about it in terms of role modeling to my student in doing the right thing and the duty to report...*

Faculty # 12: *...If you have unwell patients with dementia/delirium, your behaviour can often escalate the situation and that's what was occurring. We had met this practical nurse the day before and realized where he was coming from and talked about it. So we could choose to behave professionally, provide care to our patients, do the best we can given the complement of staff who came in and hope that maybe by example, they might consider changing...*

The faculty's statement "...hope that maybe by example, they might consider changing..." indicates the importance of role modeling. The nature of the conflict here could also involve underlying power issues as licensed practical nurses (LPNs) are lower in the hierarchy in hospitals to registered nurses (RNs) and the instructor was a RN and the students were eventually going to be RNs.

In some instances, the role modeling was for the benefit of the staff. Faculty #7: *...What we can do is help role model like when I say to the staff, 'I'm going to go over the sites with the student, do you want to come with us?' ...* Here the role modeling is for the benefit of both the student and the staff who were not using the right injection site. But care is taken to include the staff in a respectful, relationship-building manner. Efforts are made by faculty to role model collaboration with patients to try to change practice while also role modeling good communication with nursing staff.

Faculty # 15: *...I'll often try to influence that in a role modeling and encouraging sort of way rather than in a punitive sort of way...*

Faculty #9: ...*When I witnessed interactions with care providers and students that were less than kind, I would intervene, I would intercept. Generally asking, I've observed that there is something happening here and how can I be of assistance?*

These narratives also illustrate how faculty members in an informal and indirect way are also educating the staff nurses. Nursing faculty may be more up-to-date than some staff nurses on some forms of care, so they are in a position to share that knowledge with staff nurses in a deliberately collegial and respectful way.

In teacher education, there is some critique of role modeling when role modeling is practiced in the post-secondary setting rather than in a classroom with children. Similar to nursing students practicing in nursing school labs, the contexts are not the same as in the “real world.” In this study, role modeling happens in real situations and context is addressed in each situation.

5.2 Anticipating and Educating About Disjunctures

The strategies that were suggested by faculty members are divided into strategies for faculty, students and suggestions for curricular additions.

5.2.1 Faculty Learning and Support

The process by which faculty navigate disjunctures in the clinical setting needs to be taught to new faculty so that they realize that they are representing their school and are guests at the hospital. Support of faculty from the school with navigating the disjunctures was perceived as crucial. The faculty needed support from the school when faced with situations that generated moral distress. Peer support was also important to faculty and regular discussion about clinical experiences allowed faculty to reflect on the complex

process of clinical education. Faculty # 9: ... *“When I have a difficult clinical situation, peer support is really important. There are peer support people that I go to not only sound off what happened but also to collaborate with, what could I have done differently. How are you seeing me?”* ...

Participants suggested that new faculty especially would benefit from a discussion forum. Orientation to the experience of disjunctures for new faculty was mentioned several times as a way to prepare faculty to handle the disjunctures. New faculty would be better prepared to face challenges, intervene and advocate for patients and students if they were oriented to the notion of navigating through the disjunctures in a deliberate thoughtful way. New faculty suggested mentorship and the experience of shadowing an experienced instructor. The most junior faculty member that was interviewed stated when asked how she knew what to do replied, Faculty # 20: ... *“I thought about my experience as a student and asked myself, what would my instructor have done here?”* This affirms the importance of role models for faculty.

Faculty # 11: *I think what new nursing faculty need is a very conscious team leader or mentor who actively, each week, talks about the live reality of being an instructor. Again, you’d want the faculty who really represent the ideal or the philosophy of how these things should go down, to be the ones that are helping the new faculty to navigate it...*

Faculty # 12: *...Most clinical instructors are nurses and they happen to go into teaching so they’re not necessarily teachers. So we’re not educated and so we may be bringing some of the same tools that we used in our practice to our education practice. Those might not be the right tools. So we need to be concerned who are RN instructors and*

how are we supporting them to receive a, to become educated. So that doesn't mean that they have to necessarily go and do graduate work, but it could mean more practical professional days or mentorship...

Many pointed out that confidence in nursing practice increases confidence in teaching so it was a good idea if faculty maintained their nursing practice while teaching. It was evident that the navigation through the disjunctures in practice required confidence, thoughtfulness and faculty spoke of the need to evolve and adapt continuously to each situation, because there was always something different in each context.

Regular discussions amongst faculty and students, using clinical case studies involving disjunctures were identified as a way to prepare students and new faculty to handle the disjunctures. Many faculty members stressed that conflict resolution should be a key component of the communications courses taught in nursing programs. Skills promoting assertiveness and advocacy need to be part of the communication curriculum. Content around ethical practice and advocating for patients is currently in nursing curricula but what should be added is an understanding of the political nature of a publicly funded health care system. New faculty should understand how the managerial transformation of health care has impacted the ability of nurses and other care providers to provide ethical, safe and competent care.

Faculty #12: ... We talked about allocation of resources and access...how management could impact on budget and make budgetary decisions and how that might affect the patient ...And then talked about numerous nurse voices in advocating for these resources and changing the system so that we do educate the staff about

both the ethics of the need ...as well how to navigate...how do we make that system easier for a nurse who has got a full complement of patients?

When units were seen as problematic, placement coordinators had dealt with this by assigning senior clinical instructors to these units and ensuring that the same faculty member was sent to the unit over a period of time to build a relationship. Many faculty members mentioned that they felt obligated by their professional nursing standards to stay on problematic units and try to help them change. Strategies for improving practice such as leaving notes on documentation principles on the board in the nursing station were suggested.

Relationship building was named as a critical skill for faculty because many decisions in navigating the disjuncture were made with the intent of maintaining or building a relationship with staff at the unit. Communication was thoughtfully planned to be respectful and maintain the relationships with staff nurses. When best practice was lacking and if action was to be taken, then a carefully orchestrated private discussion between staff nurses and faculty took place. Faculty members stated that they always tried to treat staff nurses in a respectful manner. Sometimes, physician support was called upon. Sometimes, patients were enlisted as support for best practice. A strategy to improve practice by having faculty work with staff when students are not there helps build relationships because the faculty is now seen as part of the staff. Many faculty members stressed the importance of new teachers being aware of reality of practice being less than perfect and the need to role model and maintain best practice in the face of poor practice.

5.2.2 Student Learning and Support

Participants named specific strategies for orienting students to practice-education disjunctures. Students need anticipatory guidance during clinical orientation and a proactive discussion of the reality of the inevitable encounter with practice-education disjunctures before beginning the clinical experience.

Faculty #2: ... nursing faculty need to teach students about these encounters...just to say that they're going to happen every day, and some are going to be small, and some are going to be really big. So, we need to figure out what we need to do in a respectful and relational kind of way to maintain relationships with people we work with, but keeping in mind the patient is the first and most important part, but it's always a balance...

Students need to understand that the classroom and lab practice is not reality and that reality is messy and chaotic.

Faculty #1: ...My tactic of dealing with disjuncture is throwing the decisions back to the student because ultimately, the students, once they leave your little nest, are totally on their own...they've got to learn to make choices and sometimes in very odd circumstances...

Just as new faculty need to be taught how to negotiate for change or advocate for a patient, so do students. Role rehearsal in different scenarios was suggested with examples of types of conflict that the students might see. By being pro-active, the students are alerted to situations that may arise and can also discuss what can be done to improve the situation.

Faculty agreed that the current context of practice with hospitalized patients needing increasingly complex care required an ability to think critically and to problem solve

effectively, but also required grounding in ethics and values. The grounding in ethics would help in the decision-making when faced with moral distress of tolerating poor practice in order to maintain the relationship with staff. Students are usually intimidated by the staff nurses, and are afraid that speaking up may engender a negative evaluation of their practice. As such, they feel pressured to agree with their staff nurses. Students need the tools of assertiveness and advocacy so that they can navigate the practice-education disjuncture more explicitly. Just as experienced faculty have worked out a process of navigating and negotiating students need to be taught how to negotiate in poor practice situations. Students need to role rehearse and practice conflict resolution. Practice will assist them to be better advocates for their patients.

Faculty # 9: ...Having lab scenarios... that are conflicts, ...altercation with two parties ...and students practice using their communication skills, it's another thing to learn the theory, but when students are in a unit, there is a vulnerability that is real. It's not pretend and in that environment, where they need to draw on those skills the most...they are least prepared and least rehearsed. Practice, practice, practice, practice... so they can get comfortable in their own way of being, when they're in their most vulnerable times, in those really difficult situations in the unit and that's when they become patient advocates...

Students are flustered when faced with differences from what they have been taught so there is a need to guide them to use their knowledge to think about other ways that maintain principles but may have different steps. The larger context of practice needs to be discussed within the curriculum in a more obvious way so students learn to think about the impacts of

the changing contexts. Students also should be taught how to be flexible so that they keep an open mind about other ways of doing.

5.2.3 Enhancing Curriculum

The corporate worldview of hospital administration is sometimes in conflict with the social justice philosophy underpinning nursing education (Duchscher & Myrick, 2008). The curricula in schools of nursing are varied but address similar concepts with the goal of producing graduates who are able to meet the entry-level competencies. Ideal health care including such concepts as holistic care for clients and their families, health promotion and disease prevention, population health and a focus on the social determinants of health and social justice, are in the nursing curricula. These orientations need to be taught within a wider lens of actual nursing practice.

The issues surrounding power should be explored. Creating a truly patient-centered care model requires a deeper understanding of the concept of power and negotiating a power-with rather than a power-over relationship and how gender, race and class are related to power. It is easy for staff to blame students in dysfunctional units and in corollary, easy for the students to blame the staff. Some of the conflicts described in the interviews are between students and unregulated care aides. Students need to be taught how to recognize and to navigate situations where power is the central issue. Students should also be taught how to intervene and how to negotiate with staff. In the same way that they learn what the standards of care are, they should also be taught how to advocate for this in a diplomatic way that maintains the relationship between staff and schools.

Faculty # 22: ...I think that students need support through planned curriculum on how to deal with situations...students will say that they will not speak up when they

encounter poor practice because they're just students and they don't have the power. And they don't want to risk what could happen to their evaluation. Even knowing that the instructor evaluates, they're still worried. They also will say in the same breath that they believe once they're a RN they will speak up. And I have challenged their perspective...And so when they would say, I'm just a student. I said you are a student but my concern is that if you don't practice giving your perspective in a respectful professional way to anticipate that you'll start doing it when you're a RN, I'm not sure if you will...I recommend that you, at minimum, speak with your instructor and don't shoulder it in silence what you've witnessed...

Students may also need to be taught that speaking to their instructor and peers about the poor practices encountered are expected. Faculty cannot assume that students know how to speak up or if they perceive that they have permission to speak. The invitation to speak with their instructor and peers should be made explicit.

Chapter Summary

In this chapter, I discuss the second and third research questions of my research project: how do individual nursing faculty members navigate the disjuncture between practice and education and what can these stories contribute to nursing curriculum and the preparation of nurses as advocates for change within the health care system? I described the theme of navigating strategically in which faculty traversed the practice-education disjuncture with a complex inquiry focused process by cultivating relationships and role modeling best practice and advocating for patients. Preparation for the disjunctures for both faculty and students was discussed. Strategies were suggested for both faculty and students.

The concept of power was suggested as an addition to the nursing curriculum. In the next chapter I will analyze the themes using an institutional ethnography approach.

Chapter 6 Discussion of Ruling Relations

6.1 Introduction

In this chapter I discuss how particular ruling texts are organizing nurses' everyday lives. This analytic approach is informed by institutional ethnography, which helps to explain not only what is happening, but also why and how it is organized to happen in that way.

Smith's theoretical perspective led me to a particular interpretation of the meaning faculty narratives gave to their experiences; that is, I understood that their narratives reflected how faculty members are operating within a nest of social relations that are often invisible and hidden. The reality of nurse faculty is complex and multi-layered in both their hospital and school worlds. As nurse Faculty #13 stated... *"By now, with....all the nurses we've put out there, we should've hit enough of a critical mass to have made a difference and we're not... there's something out there that's more powerful than we are and I don't know what it is."*

In this chapter, I attempt to uncover what "it" is. A social constructivist framework conceptualizes that reality is socially organized. Smith's institutional ethnography approach does not stop with individuals' stories but continues on to examine how those everyday activities or the actualities of an individual person's experience are organized by social and institutional relations, in particular how activities are coordinated by texts.

The study of texts is essential because they are operating extra-locally and are coordinating activities of individuals across organizations. Smith (2005) describes texts as coordinators of sequences of actions, that is, there is an action, and then the text occurs within the action and coordinates the next action creating an intertextual hierarchy in which texts regulate other texts.

People's everyday activity, that is, their work, becomes the object of research but it is not just a description of the work; rather it is an investigation of what and how power is coordinating the work and through varied forms of texts (print, media, film, etc.). There is a discourse that organizes reality for participants but that discourse may be hidden to the participants or the participants may not be cognizant of the discourse. The observed behaviour is connected to a larger network of social relations that are not directly observable but are organizing the observed behaviours. Texts are recognized as coordinating: texts organize activities and are a form of consciousness. One would need therefore to inquire where a certain text came from and where does it go next and what is this text accomplishing (Rankin & Campbell, 2009).

In the following discussion, I highlight some of the specific texts, such as the College of Registered Nurses British Columbia (CRNBC) regulation texts and Canadian Nurses Association's Code of Ethics that are organizing the everyday work of faculty as they support students in their clinical placements. These texts were selected for examination because I recognized that words and phrases that the faculty used reflected the language of key regulatory documents from the CRNBC. I recognized this discourse and regulatory language because this is used in socializing students to become nurses. Nursing curriculum must conform to these regulatory texts. These texts outline the responsibility of nurses, but as the narratives illustrate, while nurses are given a great deal of responsibility, they have little power. Nursing faculty can be complicit in the reproduction of these ruling relations as the regulatory texts are always written by nurses and feedback is requested from nurses including faculty.

6.2 Ruling Relations - Medication Administration

The majority of narratives of the education-practice disjuncture were about incorrect procedures within the process of administering medications. Gibson (2001) did an analysis that deconstructed the implicit and hidden assumptions about nursing, power and knowledge around medication administration. She found that the literature around the nurses' role in medications used the language of biomedical science, law and management. The role of the nurse was narrowed to a focus on medication errors and thus legitimized the medicine's control (regulatory text) over nursing practice because the power of medications is directly related to medicine and pharmacy. The legal discourse emphasized the regulatory text of responsibility and accountability. The checking procedures that are taught in school and the policies and procedures in place at hospitals to prevent medication errors, are regulatory texts in that they exercise power and define responsible nursing care. The "incident reports" required when medication errors are made are often named as part of "quality improvement" – a management discourse that can be used to discipline students and staff nurses. Students are taught the "five rights" of administration: right patient, right drug, right dose, right route and right time. Nurses have limited power regarding how medications are prescribed or dispensed; however, the nurse is held accountable for any errors that may have been made by the pharmacist and/or doctor. The hierarchy is maintained as doctors, pharmacists, and managers are directing nursing.

6.3 Ruling Relations - Dual Consciousness

Faculty in nursing programs are also practicing nurses. As nurse and teacher, they must wear two hats. The dual consciousness of nursing faculty as both nurse and teacher creates tension for faculty as differing priorities happen simultaneously. The internal tension

arises out of this dual consciousness. There is always an obligation to protect the patient combined with the service to students as described in the narratives. The nurse faculty members are also charged with the responsibility for the students' clinical learning experience. Having to navigate this situation requires the faculty to make explicit to the student what they are doing and thinking in making the patient-focused decisions. The narratives of the faculty about their practice reflect the coordinating text of the nursing code of ethics and the regulatory body's professional standards documents. These texts are coordinating the thinking and the decisions that faculty make during the situations of practice-education disjuncture in that nurse faculty members describe a tension between their duty to the patient and their obligations to students. Nurse faculty members describe having to choose between their obligations to patients and to students as well as how they engage with that tension by role modeling best practice. Many faculty members stated that the priority would always be the patient, because for nurses in a practice context, two key priority professional standards are the safety of the public and fitness to practice. Sometimes that stance makes it seem as if faculty members are choosing the patient over the student. The fact that faculty use this language is telling of the power of the regulatory texts. The ideological underpinning that "safety to the public is paramount" appears to move the teacher away from the teaching learning partnership and into policing the student and protecting the public, which is the mandate of the regulatory college.

One of the key texts that organize the social relationships of both nurse faculty and staff nurses is the requirements of the regulatory College of Registered Nurses BC (CRNBC) that all practicing nurses must follow. The CRNBC texts directly influence the texts within a school of nursing in that all schools of nursing must go through an accreditation process. In

the policy document *Nursing Education Program/Course Review Policies* (2011), there are specific directions about curriculum, students and graduates. An example about text regulating students is as follows:

Indicators of the Standard on Students

(a) Students are informed about the requisite skills and abilities (RSAs) needed to achieve registered nurse entry-level competencies (e.g., English proficiency, mathematical, behavioural, and interpersonal skills) and the RSAs are used to support student achievement of the competencies and Standards of Practice...

The accreditation process requires schools to use many CRNBC-published documents for teaching purposes. The school's evaluation tools used to measure student performance are often based on the CRNBC Professional Standards of Practice (2012). These coordinating regulatory texts appear in education as reflected in this narrative about a school's evaluation tool. Faculty # 13: *"In order to progress to the next term, students had to be able to meet all the outcomes in clinical setting. The goals and indicators on the evaluation tool were unrealistic."* She went on to state that in "real life" new graduate nurses would never be asked to start IVs and monitor the types of equipment, as indicated in the outcomes. She knew that the school had to follow the requirements of what were considered entry-level competencies by the nursing regulatory body, yet was angry that the school would fail students because she felt that the goals were unrealistic.

An example of intertextual hierarchy in which text regulates other texts is the nurses' code of ethics or professional standards documents. Nurses are obligated to conduct their nursing work as directed by these two texts from the CRNBC and their national professional association, the Canadian Nurses Association (CNA). *"The code provides guidance for*

ethical relationships, responsibilities, behaviours and decision-making, and it is used in conjunction with the professional standards, laws and regulations that guide practice”

(*Code of Ethics*, 2009, p.2). Nurses are obligated to provide safe, competent ethical care as directed by these two texts from the provincial regulatory body and the national nursing organization.

Another group of texts coordinating the activities of the staff nurse are the managerial restructuring policies brought about by the focus on budgets. Changes in workplaces brought about by the managerial restructuring sometimes make it difficult to maintain ethical standards. In these cases, the regulatory text from the nursing regulatory body has no hierarchical power and is subsumed by the restructuring text driven by cost-containment concepts. This creates frustration not only for the staff nurses who are unable to carry out best practice as prescribed by the regulatory body and but also for faculty and students caught in the liminal space. The BC Nurses Union collective agreement contains an article in which the Professional Responsibility Report Form guides the writer through a problem-solving process to address nurse concerns related to nursing practice conditions, safety of patients/clients and nurses, and workload. This is a process that attempts to make the employer responsible, but it is the individual nurse that must complete the form. This hierarchical power of managerial text explains why nurse faculty are morally distressed by disjunctures but unable to galvanize staff nurses to consistently carry out best practice because staff nurses are directed by managerial text of efficiency versus patient-centered care.

Another ruling text, the CRNBC “quality environment” position statement states that registered nurses are responsible for creating a “quality environment,” thus shifting the

responsibility for the conditions of the workplace to the individual nurse. The CRNBC website states:

You must provide nursing care to the best of your ability given the circumstances. In addition to using the strategies for working short staffed, assess the environmental safety needs of your clients and minimize any immediate risks. In hospitals or residential care settings, for example, it may be necessary to move clients to ensure appropriate access to equipment such as oxygen, suction and call bells or to maintain privacy. In other practice settings, triage, prioritize and regularly review caseloads, clients and program needs.

The focus of regulation is on individual practice not on collective or structural influences. Yet it is the employer, not the individual nurse, who makes the decisions about nurses' workload and systems. Perhaps in the face of the impossible, hospital nurses do what they can with their constrained agency or they leave the profession. This is evidenced by the attrition of new nurse graduates, as mentioned previously. The statistics collected in Canada about the attrition of new nurses is not reliable because, although the regulatory bodies can track how many new nurses did not renew their practicing registration, they do not track them if they are practicing elsewhere, because the regulatory bodies have only a provincial mandate.

6.4 Ruling Relations - Role Modeling

In some narratives, faculty members were hopeful that they could change poor practice by role modeling best practice. This sense of obligation to role model is partly directed by the regulatory body's practice and professional standards documents. Both staff nurses and nurse faculty have the same texts organizing their social relationships and these

are the regulatory requirements of the CRNBC that shape all nursing practice. There is a process outlined by CRNBC describing what to do if a nurse works in a place that allows poor practice. Faculty # 17: *“A nurse had, indeed, assaulted a patient and then it became an issue for me about what should we do about it in terms of role modeling to my student in doing the right thing and the duty to report.”* The faculty is role modeling the “duty to report” which is language from the CRNBC. The published Practice Standard titled “Duty to Report” explains very explicitly, in over four pages, what behaviours by registered nurses need to be reported to the regulatory body.

An excerpt from the Duty to Report Practice Standard states:

...Nurses have legal and ethical duties to report incompetent or impaired practice or unethical conduct of regulated health professionals. It is important for nurses to understand when to report, what to report and how to report, and to know what is required of them both legally and ethically.

In B.C., the Health Professions Act establishes a legal duty for nurses to report situations in which there is a good reason to believe that a health professional’s practice is impaired or incompetent and may pose a significant risk to the public. It is interesting to note that there is no obligation to report poor working conditions. The Act also requires nurses to report any sexual misconduct of a health professional. The text above is an example of a ruling text and faculty, as registered nurses, must report unethical behaviour. The rigor of the language reflects the language in the Health Professions Act, Part 3 — Inspections, Inquiries and Discipline — which spells out details in legal language of what must happen if registrants are found to be demonstrating professional misconduct (which is defined as sexual misconduct,

unethical conduct, infamous conduct and conduct unbecoming a member of the health profession).

6.5 Ruling Relations - Background to Clinical Placement Problems

As mentioned before, there is a shortage of placements in the urban area in which the study took place, and the threat of losing a placement impacts how faculty members navigate the disjunctures.

Faculty #7: ...And placements are so hard to access ...I really think that's an issue because unless poor practice is really blatant and extremely serious, some people aren't going to come forward to address poor practice issues because the unit may just say, "Okay ...we're not taking this group next term, we're taking another group." I mean, we don't have enough placements for our students now, so, everyone's walking on eggs...

There are several reasons for the shortage of clinical placements. The changes of the health care system that directly impact the availability of student placements are the downsizing of acute care units, increased numbers of nursing students in entry-to-practice programs in BC and competition for specialty placements. Each of these will be explained in more detail.

Downsizing of acute care units

Smaller units can only physically accommodate a small group of students. Acute medical and surgical units have been downsized in the last two decades as increasing numbers of patients go for diagnostics, smaller procedures and surgeries through ambulatory care settings rather than staying overnight on a hospital unit. The evolution of increased ambulatory care and day care surgeries were partly in response to new technologies that allowed diagnostic procedures and surgeries to be less invasive, thus requiring shorter

hospital stays. Incentives to adopt these changes included the greatly reduced cost to the health care system of an ambulatory-care patient versus a hospital-stay patient as well as pressure from for-profit biotechnology companies, eager for sales of their new technologies to hospitals. The ambulatory care units and daycare surgical units have not taken students to the same degree that traditional medical and surgical units had in the past; patients do not require as much nursing care and there is limited availability of patient contact for students. As well, early discharges of medical and surgical hospital-stay patients have created a situation in which only the especially acutely ill patients stay in the hospital, because everyone else is discharged home and to home care if needed. This orientation has been contested, and it is argued that in the health care system restructuring (Peters, 2013) patient care has been downloaded to individuals and to families. The outcome of this for student learning is that there are fewer patients in hospitals that are appropriate for student care, and the home care system is more difficult for students to access. Home care cannot accommodate many students because the supervision of a group of students is not possible without the cooperation of individual home care nurses because students would be spread out across a geographical region rather than being in one or two physical spaces as on a hospital unit. The supervision of students in community settings means a smaller student-to-faculty ratio. On a hospital unit, that ratio is one faculty to six to eight students, while in a community home care setting the ratio is one faculty to three to four students. This is a cost that schools cannot afford as cost containment also has impacted public education in a neo-liberal political climate (McCoy, 1998).

Increased Number of Nursing Students

Perhaps the answer to the shortage of clinical placements is to decrease the size of the nursing classes? However, that is not a solution because schools are being pressed to produce more graduates. There has been an accompanying increase of student seats in nursing programs because an upcoming shortage of nurses was predicted with the retirement of the baby boomer cohort of practicing nurses. The unplanned combination of more students but fewer placements has added to the placement shortage. Linked in the ruling relations is the provincial government Ministry of Health, because they are responsible for health human resources. The demand for nurses goes up and down over time much like the demand for many professions. However, currently and since 2002, the number of nursing graduates has been increasing because a shortage has been forecast by the employers. Based on the age of the practicing nurses and their looming retirement, the national nursing organization, the Canadian Nurses Association (CNA 2009) has forecast a national shortage of 60,000 FTE registered nurses by the year 2022. The Canadian Institute Health Information (2012) noted that the average age of a nurse in Canada was 44.6 years and more than one-third (36.0%) of the registered nurse workforce was aged 50 years or older. The BC Ministry of Advanced Education increased seats in entry-to-practice BScN and practical nursing programs to address the anticipated nursing shortage.

In BC, another factor that led to a further increase in the number of students was the privatization of practical nursing education, which led to a proliferation of programs all needing clinical placements. Historically, there were only four public college practical nurse programs in BC and no private programs; approximately 200 practical nursing students graduated each year. Today in BC, there are nine public programs and 40 private for-profit

college practical nursing programs. There are now 1100 practical nursing graduates per year and of these 73% are graduates of private for-profit colleges. What factors led to this privatization of nursing education in BC? In the spring of 2001 a new Liberal government headed by Gordon Campbell, took office. In its June session, the throne speech contained four references to deregulation and four references to privatization.

...Minister of State for Deregulation to help all job creators become more competitive. His objective is to eliminate unnecessary, expensive, job-killing regulations, without compromising environmental standards, public health or public safety. All ministers have been given a firm mandate to ensure my government makes good on its deregulation commitment to reduce the regulatory burden by one-third within three year. Retrieved Nov. 29, 2006 from <http://www.leg.bc.ca/37th2nd/4-8-37-2.htm>

That same spring, the health care system suffered a long strike by nurses who were then legislated back to work. Many of their work condition complaints were based on the shortage of nurses. The need to increase nursing seats in the public colleges became a goal of the new government. The Ministry of Advanced Education, in consultation with the Ministry of Health, funded five more public college practical nursing programs. Both practical nursing programs and BScN programs received extra seats, but the practical nursing programs were more attractive to the government because they were shorter programs and could produce graduates faster and they were paid a lower salary than BScN graduates. For-profit colleges seized the opportunity and began to offer practical nursing programs. A rigorous program accreditation system was in place at the practical nursing regulatory body, the College of Licensed Practical Nurses British Columbia (CLPNBC). But with five new public programs

needing accreditation; the Ministry of Health pressed the regulatory body to hasten the process, which in turn helped not only the public programs but also the private for-profit programs to obtain expedited approval to begin a nursing program.

While no specific policy stated that for-profit colleges should proliferate, the provincial context of deregulation and privatization, coupled with the crisis of the nursing shortage, combined to create a supply and demand market opportunity for the profit-making schools. Although the hospitals are publicly funded, the neo-liberal message from the provincial government was that the hospitals were expected to treat the private for-profit and public nursing programs equally and share scarce clinical placements. Even with the additional new public programs, the demand was great and there were long waitlists for admittance to the public programs. Reminiscent of the current private-public health care debate, an applicant could skip the waitlist by registering at a private for-profit program. Another factor that aided the for-profit colleges was the appointment in 2001 of a new executive director for the practical nursing regulatory body who did not come with a preconceived notion that public sector programs were of better quality and expedited the accreditation of new programs whether they were public or private in the same manner. Until 2001, no private for-profit colleges had ever been accredited to deliver a nursing program in BC, so there has been a dramatic turn of events and today there are over 40 private for-profit practical nursing programs that are now competing for clinical placements. This tripling of practical nursing graduates has had a large impact on the availability of placements.

Competition for Specialty Areas

The CRNBC's traditional stance of requiring that all areas of nursing must be part of the education of an entry-level nurse further adds to the challenge of maintaining placements.

Maternity, pediatric and psychiatric nursing are considered specialties by urban employers and new graduates must take postgraduate programs to work in these areas. The postgraduate programs in these areas need the specialty placements and students in entry-to-practice programs must compete with them for these placements. The regulatory body's requirements for clinical practice in all areas of nursing are based in historical traditions where general hospitals had their own schools of nursing and thus clinical placements were not a problem. They were apprenticeship programs in which student nurses rotated through all the wards in the hospital. The hospital schools of nursing had no concerns about maintaining clinical placements because both school and hospital units were under the same administration. The move from hospital-based schools of nursing to post-secondary based schools of nursing took place in the 1970's. By the mid-70s, most hospital programs had moved from hospitals to colleges or universities. The change was championed by nursing associations such as the Registered Nurses Association of British Columbia (RNABC precursor to CRNBC). The nursing associations could foresee that the graduates needed to be prepared differently for an evolving health care system. The health care system has changed but the CRNBC's accreditation requirements continue to require clinical experiences in all the areas of nursing because the entry-level graduate is considered to be a generalist.

The CRNBC continues to require clinical experience in all areas of nursing practice although placements in the specialty areas are few. Nursing programs in the post-secondary system must continue to keep the scarce clinical placements that they have in order to maintain accreditation status. Simulation of this specialty content has been used extensively in many nursing programs in Canada and the USA and proven effective in preparing students for real practice, yet the CRNBC will not allow substitution of clinical experiences by

simulation. In the recognition process that all schools of nursing must go through, replacement of clinical experience with simulation is not acceptable. Clinical experience can be augmented but not replaced by simulation.

6.6 Power and Hierarchy in Practice Settings

The practice setting is embedded with issues of hierarchy and power. The historical roots of nursing are militaristic and hierarchy is embedded in the culture of nursing. In Duchscher and Myrick's (2008) study of the oppression of new graduate nurses, they write: *"Oppression is an experience that results from dominating patterns of ideas or structures that characterize, normalize, and perpetuate unequal relationships and role determinations within a social system."* (p. 194)

Students and faculty are in a liminal space as guests, not belonging to the culture of the hospital but participating in it. The faculty are expecting students to practice in a specific way yet many staff nurses take shortcuts or do not always use best practices. The power imbalances affect the experience of this liminal space. Between staff nurses and faculty, formal power resides in the staff nurse who is the hospital employee and has the knowledge of the patients and how things work on their units. The nursing faculty is part of the larger culture of nursing but lacks formal power in this setting. The affiliation agreements that exist between schools and health authorities deal with faculty and student responsibilities (see Appendix D). Faculty may possess hidden power related to their higher levels of education and associated privileges. The following narratives reflect how faculty perceive students' fear of staff nurses. This fear is a visible indication of explicit power issues.

Faculty #4: *I think all students are intimidated by the staff. Even the staff members that are twenty-two years old and just out of school, they intimidate them...*

Faculty # 9: *...So the student came to ask me permission to go and close the drapes and I found that interesting because already in semester 1, the students in my view, have a perception of power over, and so they were seeking permission to close the drapes on what was a humanitarian moment (patient was lying exposed in bed with no drapes protecting privacy)...*

Faculty #13: *“But I think in practice ... students learn that it’s okay to have poor practice because the students tip toe around it and we all do...”*

Underlying power concerns present in the narratives are stories of confrontations with care aides. Care aides have little symbolic power and in a hospital hierarchy they are at the bottom. Additionally they are unregulated care providers, who have been trained to provide basic care and are not under the Health Professions Act. As such, the nurse who assigns them their work must take responsibility for the unregulated care providers’ practice. The nurse who is governed by the regulatory text has power over the care aide.

Power matters are evident in the story from Chapter 1 about hanging patients in slings. The response of the hospital administration seemingly ignored the patients and instead focused on the break in the hierarchical procedure of the chain of communication by students and faculty. The response from school administration was similar because it focused on the loss of placement and the hierarchical chain of communication. Faculty and students were admonished for not coming to the placement coordinator at the school first before taking their own action. The elderly patients were forgotten because patients and families are at the bottom of the hierarchy. The patients in this narrative were all elderly and mostly cognitively impaired so were not able to advocate for themselves; families were probably unaware of this practice because visiting is discouraged in the morning, as visitors get in the way of care

routines. Students might have worked in collaboration with the care aides to change the situation if they had examined the situation from the care aide's perspective. The situation for many care aides is that they are responsible for ten dependent patients requiring total care. The routine on the unit was to get all ten patients up and dressed and in a chair by late morning. For the care aides, there is never enough time. Hanging the patients saved time and if they had toileted the patients properly, they would have been unable to complete care for all of their assigned patients. In their thinking, the slings were necessary so that they could get to all of their patients in a timely manner. Which was worse: hanging in a sling or being left in bed all morning? The care aides had been taught that it was imperative to get the patient up, dressed and ready for the day by late morning. Perhaps the students and faculty could have looked at the workload issue, which is closer to the root of the problem. How is the workload in a unit assigned? In the meeting, the administrator being a nurse, when confronted with the example of poor practice, admitted that they were responsible for stopping that practice, but found that because of the workload, they could not. They were unable to stop the practice because of the budget, which did not allow for more care aides to be hired. It may be that the care aides have too many patients assigned to them and cannot give the kind of care that they may want to. This leads to the question of workload which Rankin and Campbell (2006) explain is decided not by local conditions but by regional administrators (who are not nurses) but have made mathematical calculations to decide how many care providers will be allocated. As noted above, it is not just who is making these decisions but the fact that the budget for health care is inadequate. Therefore, the power relations can also be traced to a government policy level.

In another narrative from Chapter 4, the faculty member describes an incident with a care aide in which a student was reprimanded for chatting with a patient and the patient was reprimanded for becoming an “attention seeker.” The care aide in this narrative probably saw that she would never have enough time to chat with a patient and was afraid that the patient would expect this one-to-one attention on the days that the students were not there. In this narrative the care aide, as someone at the bottom of the unit hierarchy, is angry with the only other person on the unit who is lower on the hierarchy scale: the student. However, this student has hidden power in that it is known that she will become a registered nurse and registered nurses have power over care aides. The care aides in these narratives have little or no voice in their units. Students are there temporarily and not truly part of the unit but rather are only guests and so the lack of power is temporary and situational whereas for the care aide it is the context of everyday life.

The unregulated care aides could be identified as an oppressed group. Care aide work is similar to nursing work in that it is physically demanding, involves risk of infection, risk of physical injury from combative patients, and is emotionally charged, but care aides are paid a minimum wage with little possibility of advancement. Chaudhuri, Yeatts and McCready, (2013) surveyed 362 nursing assistants (care aides) in one southern state in the USA for factors affecting their empowerment. They found that race and supervisor support were the key factors and also that there was a paucity of research about care aides. However, there is growing use of care aides as a managerial approach to cost-cutting in the United Kingdom (Mckenna, Hasson & Keeney, 2004) and Canada. In Canada between 2001 and 2006, there was an increase in the number of care aides in comparison to nurses. In 2001, the number of care aides was 57% of the number of RNs, and in 2006, the number of care aides was 62% of

the number of RNs; that is, there are more nurses than aides but the proportion of care aides has grown. (Statcan, 2010). Considering the number of care aides who are actively providing care, it is surprising that they have so little voice, but considering that they are not autonomous and are supervised by nurses, they have relatively less power compared with nurses.

Nurses control the work of care aides by the regulatory text that requires nurses to ensure that care aides have the necessary training and the experience. Spilbury and Meyers (2005) found that registered nurses tended not to involve care aides in discussions of patient care and discharges. They found that the interactions between care aides and nurses were reminiscent of the relationship between nurses and doctors. The care aides acted in a way that “...appeared subservient to the RNs. However, this game was one of the ways in which the power of a ‘lower participant’ in the hierarchical structures of nursing was observed to manifest itself in practice” (p. 78). In this qualitative study, they found that care aides exerted some power through withholding or strategically using their organizational knowledge. Roberts, DeMarco and Griffin (2009) did a systematic review on the literature of oppressed group behaviour in nursing and found that oppressed group behaviours are often found in nurses. If there is oppressed group behaviour among nurses, it also must be present in the care aides.

Young (1990) describes five forms of oppression: exploitation, marginalization, powerlessness, cultural imperialism and violence. This concept had been used as a comparison between doctors and nurses, with nurses being the oppressed group. However, in the hierarchy of the staff on a residential unit, the care aides are the more oppressed group. Exploitation occurs when a process of transfer of results of labour of one social group benefits another group. Care aides are at a much lower pay scale than nurses.

Marginalization occurs when people are expelled from useful participation and opportunities to exercise capacities are blocked. Care aides are not often asked for input and are marginalized in the unit with little or no voice. In most long-term care units, care aides outnumber the nurses yet care aides have no voice. Their education is much shorter at six months than nurses who are at diploma or degree levels. Care aides are not regulated by legislation or codes of ethics. Although on a long-term care unit, the care aides are the largest group of healthcare providers. Historically, they have little power and it is the nurses, doctors or managers who make decisions. Less powerful people lack authority, status and sense of self. In the long-term care setting, care aides have little authority with decision-making related to patients and are lower in status to nurses. No one asks them to participate in decision-making. Cultural imperialism occurs when there is universal acceptance of the dominant group's culture and experience and these are represented as the norm and not contestable. The hospital hierarchy is perpetuated in residential facilities. Systematic violence occurs when members of some groups fear random unprovoked attacks that damage or humiliate a person (Young, 1990, p. 61). Given the vulnerability of patients, they can readily be positioned by care aides as a safe, convenient dumping ground for venting out-of-control emotions.

There is a traditional hegemonic hierarchy on units where abuse of power may occur at a subconscious level. Class and gender issues are also underlying these power relations because care aides are predominantly female and are often women of colour, or immigrants from a variety of source countries where English is not the dominant language. Some of them are nurses or doctors in their home countries who are unable to access licensure here in Canada. These larger social and institutional relations enable violence to the patient and

student, by care aides. By understanding the power issues that are behind the behaviour of care aides, students could plan for better relations with the oppressed group by sharing whatever power they have. However, there are tensions related to working with care aides because care aides are replacing nurses: *“VIHA announced it would replace nurses with care aides on key units. Twenty-six nursing positions are being replaced by care aides...”* (Vancouver Island Health Authority website, Aug 26 2013).

In the academic world, the ideal is taught that the patient should be of central concern and nurses should share power with patients and others involved in the care of the patient. This power-sharing is difficult to practice within such constraints. The staff nurses do not have time to educate or to direct their patients to the resources that they will need to make an informed decision and so often make decisions for them in the name of efficiency, which is discussed in the following section. Brunner (2002) discusses how the predominant conception of power continues to be power as authority and dominance over others or things – “power-over.” She argues that the concept of “power-with” or “power-to” exemplifies the experiences of women where power-with/to is viewed as collaborative, inclusive and consensus building. Faculty # 15: *“But also, in those situations where I notice that the practice is poor or I think that the way of being with patients could be more power sharing.”* However, there are many structural impediments because nurses are limited in power sharing by regulatory texts wherein care aides are clearly restricted in their caring responsibilities. In this way the established hierarchy is maintained with the care aides, patient and the students at the bottom.

6.6.1 Staff Mix

The changing of staff mix is a cost containment practice. Instead of having registered nurses who have the highest salary, work is shared with licensed practical nurses (LPN) and unregulated care aides. These two groups of health care providers are paid at a lower salary. Registered nurses fear replacement by practical nurses and care aides, and this adds to a stressful workplace, which is not conducive to student learning. The registered nurses who are left on the unit may feel antagonistic to the newcomers. Another factor is that the health care world is very hierarchical and in this hierarchy, the practical nurse is below the registered nurse and the care aide is below the practical nurse. So in the registered nurses' perspective, they now have to work with a team with lesser-trained people. There were several narratives that voiced concern over the staff mixes and the territorial competition between the two nursing groups. In the following scenarios, the faculty member is finding the changes on the unit of staff mix challenging. The faculty member voices the stress of constant changes that are taking place in the workplace. This is a reality with the ongoing restructuring of the health care system.

Faculty # 11: *...But the surgical floor that I teach on has LPNs caring for surgical patients and infusions but here they've said their patient acuity is too high for LPNs and the hospital tried and they had it overturned. So, good for them. They were really, a progressive educator, the manager and she works really hard for RNs...*

Faculty # 23: *...And I think a lot of it had to do around that time too when LPNs were brought onboard and the nursing staff had reduced a little bit and so there was issues there as well between the two professions instead of sort of coming together collectively, it was kind of becoming a bit more territorial...*

Faculty #24: *...LPNs on the ward, on the unit, appeared to have a lot of power and...LPNs on the unit felt threatened by the students. This was just at the point where we were moving into a degree and the LPNs hadn't moved to full scope practice...So I think that probably a lot of the LPNs might have been quite frustrated by their role and the students, we had a lot of concern from instructors and from students about the way they were being treated on the unit. It just wasn't very respectful and no amount of dialogue seemed to help in getting our students the learning experiences that they needed...*

Faculty members reflected the concern of the staff RNs about the LPNs role-encroachment and generally had a negative tone in discussing LPNs, recreating and sustaining the hierarchy. Faculty # 12: *"...there is a mix of staff... if you go into places now where the RNs are displaced by LPNs and the LPNs can't pull their weight because the place is too acute, it can lead to a lot of frustration and a lot of missed care."* The shift to higher utilization of LPNs is reflected in a policy document:

During 2006 policy discussions between the Ministry of Health, the Health Employers Association of BC, health care employers and the Facilities Bargaining Association, representatives discussed many of the factors that contribute to effective utilization of Licensed Practical Nurses (LPNs) and Care Aides. Based on these discussions the Ministry of Health agreed to fund a report (the Report) to: 1) examine the evolving utilization of LPNs and Care Aides across the province, 2) identify some current approaches that promote effective utilization and 3) recommend strategies that would support optimal utilization of LPNs and Care Aides in the future...

(Facilities Bargaining Association, 2006)

6.7 Structural Adjustments in the Health Care System

The faculty narratives describe conflict and tensions brought about by poor practice. The moral distress of both faculty and staff nurses are caused by the inability to utilize best practice and to provide patient-focused care. Best practice may not be possible because of the corporate and managerial approach to health care. Rankin and Campbell (2009) present a nursing perspective of the restructuring of the health care system using an institutional ethnography approach.

Our analysis exposes the pressures that participating in this new coordination exert on nurses to standardize their efforts. What is being accomplished is an organization of efficiency that competes with and routinely subordinates nurses' professional judgment about what should be done for their patients' care and wellbeing (p. 2).

Examples of a standardizing text are the clinical or care pathways that outline a surgical patient's normal recovery and are widely used in acute care settings. They are agreed-upon texts by the non-nursing administrators who need a clear and efficient way to measure recovery. Campbell and Rankin (2009) expose the ruling nature of the clinical or care pathway.

This social construction of knowledge begins, for any patient and nurse, with a care path form that is included in the hospital record—and it becomes for the nurse a working text. The text directs nursing interventions and makes them visible for monitoring. Often the care pathway is supported by pre-set and authorized physicians' orders. In some hospitals, especially those that have made the transition to the electronic medical record, patient care (and variances) can be managerially

monitored hour by hour, day-by-day...Nonetheless, the care pathways align the nurses strongly to the managerial agenda (p. 15).

These pathways determine the length of hospital stay. The length of hospital stay is a term organized by the Federal Ministry of Health in their bid to measure and collect statistics to control health care cost. Nurses are pressured by these pathways and cannot use their professional knowledge to make clinical decisions based in individual patient needs.

Campbell and Rankin (2009) found nurses felt hurried and distressed that they did not have the time to take care of individual patient needs because all patients did not move along the clinical pathway in expected times. Some patients were elderly and required more time for recovery, some patients were more anxious and required more teaching and reassurance, but the nurses were not able to provide that extra time and still meet the demand to discharge the patient according to the pathway. Nurses' knowledge is dismissed and the clinical pathway created by statisticians is now organizing nursing care. Under the ruling relations of clinical pathways, the individual nurse does not really have any power to make autonomous decisions — the standardized text created by bureaucrats far from the bedside and unknowing of individual patient contexts has already made that decision.

Faculty members as nurses empathize with the moral distress experienced by staff nurses. This narrative illustrates how the faculty understood the constraints staff works under, and how the care that is possible under these constraints is then labeled as poor practice.

Faculty # 12: *...The disjuncture between what we teach as patient centered care is difficult in the early phase of their career, because we don't really realize the sort of*

efficiency models and the reasons that the hospitals run the way they do and there really is very little scope for patient centered care, in an acute care hospital...

The faculty person is empathetic with the staff nurses who are unable to give good care because of the workload. Attention is called to the lack of patient centered care in acute care settings due to the efficiency model.

Faculty # 19: *...Not enough nurses, not enough good nursing care, too many ill patients. And then the other thing is getting them out as quickly as possible so they can fill the beds. ...They had people waiting for those beds and ...the patient goes home much sicker than they did before... the patients end up sicker and the RNs work harder...under a lot more pressure because the patients are so ill. I can remember having multiple patients that were so ill and having to watch them constantly and just being terribly afraid I was going to kill someone ... there is always a tension between what you have to do in order to take care of six patients. What you have to do and what you know you're supposed to do as an RN. ... Do you see, so there's the sort of disjuncture between education, what we have to teach the students is good care and what they're seeing on the unit...staff may be good nurses but they're just doing what they have to in order to give care.... ...I think there's a period of enculturation... They started out doing everything by the book and then they get pressure probably from fellow nurses because they're not getting the meds out, they're not getting stuff done on time and as kind as they may be, their fellow nurses, the work has to get done and the reality is ... the patients are too ill to give the kind of care that an RN feels the patient requires...*

In the preceding narrative, the faculty was speaking about her nursing practice and recalling the tension between what needed to get done and the nursing care that had to be set aside in order to complete the assigned workload. She recognized that how she had practiced would not be how students were expected to practice. She is questioning the ability to be a competent caring nurse given the context of the current health care system.

In a previous narrative, faculty stated that they understood that the reality of nursing practice is not best practice: *“I’ve worked in medicine, I know it’s ridiculous to sit down and feed somebody his or her 35 meds. You’ve got a million other things to do...”* Staff nurses speaking about poor practice around medication administration acknowledged that they were taking shortcuts but could not help it because they were so busy. The nursing care cannot be provided to patients as it is taught to students; nursing care is coordinated textually by forms, pathways, flow sheets, electronic health records and databases that may be useful in tracking and determining efficient use of nursing time, but they actually impede nurse-patient relationship or decision-making using nursing knowledge. The efficiency models operate outside the patient-nurse relationship to coordinate nursing actions. The need for cost-containment has driven health care reform and these reforms have led to lack of patient-centered care and caused moral distress in many staff nurses and faculty. The Canadian health care system is constantly evolving and concerns about sustainability of the system have become the main driver of changes.

Campbell and Rankin (2006) found that a cost-orientation was embedded in care-related practices and nurses have adapted to these changes. Their professional knowledge and caring skills have been undermined because they are often unknowingly ruled and their

actions coordinated by managerial texts (policies and procedures). As nurses accommodate this managerial perspective, they may also be perpetuating this perspective.

... Despite assertions that health care reform and hospital restructuring are expected to improve nursing care (or at least leave it unfettered, making it more patient-centered and socially relevant), we have nurses' work with patients being reformed in troubling ways. Many nurses accept the current requirement to develop more efficient ways to nurse patients and to act within the organization's restructuring mandate... their work articulates patients and their needs to decisions made objectively in a reformed system that has been redesigned to know patients and their needs as numbers and categories. (Rankin & Campbell, 2006, p. 164)

In Rankin and Campbell's (2006) conclusions, they found that the goals of restructuring of hospitals over the last 30 years are not nursing's goals, the result being that the activities of nursing care have been subordinated. This results in angry and frustrated nurses, or nurses who have been caught up in the managerial practices.

Hospitals' managerial practices, with the emphasis on efficiency, have shaped the role of the hospital nurse to be more technical and efficient. For example, in urban hospital units, care is specialized and in one unit, nurses may only care for patients having cardiac surgery and on another, orthopaedic hip surgery. Nurses become very efficient at caring for patients with the same or similar problems and they are not using the generalist education that they all received. Perhaps their transition or reality shock is related to the differing expectations of new graduate nurses and their employers. The new graduates are expecting to nurse patients using a holistic perspective but they are only becoming efficient with caregiving to patients with the same or similar conditions. The employers complain about the

gap between practice and academia. The gap may be the differing expectations of new graduates. Academia is producing generalist nurses able to provide care in many settings to clients and their families with many different problems while the hospital system is expecting technicians. Managerial practices have led to the consequence that people who are not nurses are shaping nursing practice.

Language Tensions

Another stressor named by faculty members was the language tensions, where staff nurses would speak other languages. This practice created distress for faculty members and students, because they felt that the patients were affected by the inability to communicate with their nurse. In the following excerpts, faculty is upset by the exclusion of patients and students believing that the lack of mutual language affected care.

Faculty # 10: ... *Staff were speaking to each other in this Chinese dialect ...They would be making fun of patients in their own language, being disrespectful in their own language about a patient. Or the other thing that was observed is that they'd go in the patient's room, two of them, and they'd be talking over the patient's head in this other language and ...basically ignoring the patient...*

Faculty #19: ... *We teach patient focused care, right, and one thing is that we have a very diverse staff and a lot of different cultures and different languages being spoken and which is fine, but what the students came to me about was that there were nurses speaking over the patient in their own language. For me, it was very difficult, because I teach students who are from other countries, so when they come into the clinical area, they're very vulnerable, they don't know how things work in Canada so*

when they observe them, they think that's the right way. So when they spoke to me about this situation, I did react quite quickly because I immediately think of the patient and how uncomfortable that patient must have felt. So we had a discussion related to that and I tried to get them to relate to the patient, how that must've felt for them as a patient lying in bed, again, very vulnerable, having things done to them and the nurses who are caring for them who they've placed a lot of trust in, are speaking to them in a language that they cannot understand...

The faculty point out that the morale on these units was poor. Perhaps the language tensions were related to racial tensions that the staff nurses were experiencing. Canada is a multicultural society and many languages other than English are spoken. Not only are the caregivers racially and culturally diverse, so are the patients and students. Patients in these vignettes may have felt excluded but there must have been several patients who were happy to have a nurse who spoke their language. The health care system declares that the language of the system is English but on some days, very few patients speak English. Of the 24 faculty members that I interviewed, only three were of other than European descent and only two spoke their language of origin. This is generally representative of faculty members in nursing programs. The regulatory body, CRNBC, has requirements for English fluency before the registration process can begin and only two tests are accepted, the IELTS and the CELBAN, with fairly high qualifying scores. It would seem that the staff nurses who choose not to speak English are doing so deliberately since they had previously demonstrated English fluency in order to obtain a practicing license. Lawton (2008) writes on the discursive nature of the "English Only" policy in the USA. She analyzes the policy and concludes that:

While a pluralist 'front' may be presented in certain places in the texts, this pluralism (which advocates a multicultural, multiethnic and multiracial society) is only tolerated to the extent that it does not involve languages other than English in the public sphere, and there are actually underlying ideologies that promote assimilation and monolingualism...What appear to be common sense arguments about providing immigrants with upward social mobility and preserving the English language and American identity may instead be motivated by other underlying ideologies that a detailed textual analysis is able to expose...(p.100)

There are ideologies of assimilation and regulation coordinating the belief that English must be spoken. In Sackville's (2012) study of English policy at a post-secondary institution, she found that the policy texts were based on a discourse of homogeneity in which difference is construed as a negative. This language tension is another manifestation of the hierarchical climate found in hospitals. Immigrant nurses are often viewed as "different" and may become targets for uncivil or bullying behaviour.

6.8 School of Nursing Setting: Maintaining Hegemonic Hospital Practices

Power imbalances are maintained in schools of nursing, because faculty members have been educated through hospital experiences. Nursing faculty members, although no longer staff nurses in hospital settings, have been socialized to the nurse role in hospital settings. Although there has been a curriculum "revolution" in which the faculty members are expected to be mentors and partners in the student's learning experience, it has been difficult for many faculty to move from their own socialized "field of practice" (Myrick & Tamlyn, 2007). Most faculty have been trained within the hospital hegemony, they then unconsciously recreate oppression in the school, such as setting oppressive policies using the

“safety to the public” justification. For example, only 10% absence allowed, 100% accuracy in dosage calculation exams with no rewrites and only two failing marks allowed in a program. Bourdieu’s (1990) concept of the field of practice and the maintenance of the durable relations of domination explains why these conditions persist. Bourdieu (1990) sees power created culturally and symbolically and constantly re-legitimized through interplay between agency and structure. Understanding these invisible forms of power assists in unmasking oppressive structures (Waquant, 2005).

Many faculty members highlighted the importance of understanding the contextual nature of actions.

Faculty # 11: *...Sometimes they (students) see poor practice and sometimes they just need to contextualize things.*

Faculty # 3: *...I try to generalize and say that you will see that in nursing...sometimes you do the best you can, and you’re faced with difficult situations, like in this case, you’re dealing with a large volume of clients, limited time frame...So, what I do is I problem-solve it through with them and say: what and why are they making this choice? ...You look at the pros and the cons, and you see why they might be doing this...*

Faculty #7: *...Regardless of what we do in the school, we try and tell students that they’re going to see things that aren’t going to be the way we teach them... but that doesn’t mean they’re always wrong. There’s a context in which they do that, and they have to critically think through that context...*

In these comments, faculty members have an understanding that practice cannot be always as taught in school, and that there are contextual reasons for making decisions and the students

are taught to consider these. Are these nurses being swept up in the hospital restructuring? As noted earlier, Rankin and Campbell (2006) find that nurses themselves could be adopting the efficiency models and inadvertently disrupting the traditional nurses' work. Rankin and Campbell (2006) conclude that the tide of restructuring and the loss of nursing's traditional ways of knowing and acting cannot be turned back.

Roberts, Demarco and Griffin (2009) describe a successful four-week program for new graduates who are especially vulnerable to violence from staff nurses. It was a four-week residency program combined with an intensive education designed to shield against the violence by teaching scripted responses that correlated with the 10 most frequent forms of lateral violence and speaking directly to the hostile staff member. It was found to be effective in reducing attrition. Pauly, Varcoe and Storch (2012) found that nurse educators face challenges in balancing competing curriculum demands and ethic courses to help students manage the moral distress. They suggest a relational approach to conceptualizing moral distress with both individual and institutional factors.

6.9 Chapter Summary

In this chapter I have further analyzed the narratives critically and uncovered, explored and described how the everyday practice-education disjunctures are organized. I have explained what is happening, why and how it is organized to happen by the ruling relations and regulatory texts coordinating the actions of staff nurses and nurse faculty.

The discussion arising is about how regulatory text from nursing organizations such as CRNBC plays a key role in shaping the dual consciousness of faculty. The faculty's efforts at role modeling are also coordinated by CRNBC texts. The shortage of placements, which puts faculty in difficult situations where they are tolerating poor practice, has many

layers. The power issues in the workplace add to the stress of faculty and students on hospital units embedded with hegemonic hierarchical practices. Staff in hospitals cannot carry out best practice because of efficiency and managerial models of care that become the textual forms of ruling relations which lead to frustration and moral distress. Cost-containment measures, together with changes in staff mix, have created chaotic conditions in those units where staff had little input or preparation for change. There are also language issues reflecting underlying hegemonic power. In many respects, the narratives of faculty who participated in this study illustrate how they are also playing a part in unknowingly perpetuating the power imbalances in schools and in hospitals.

Chapter 7 Findings and Implications

7.1 Introduction

The purpose of this chapter is to summarize my findings in response to my original question and to connect ideas across the preceding chapters. First, I consider findings in relation to the practice-education disjunctures. Second, I discuss research findings in relation to theory and evidence presented in the literature review. Third, I discuss the implications of my study on practice and suggestions for future research. Fourth, I comment on the limitations of my study and finally conclude with some personal reflections on what I have learned, what surprised me and what has changed in my practice as an educator.

7.2 Summary of Practice-Education Disjunctures

7.2.1 Research Question One

What meaning do individual nursing faculty members give to their experiences of the disjuncture between what is taught about ethical and best practice in nursing and nursing practice that is found in many clinical practice sites?

At the everyday level, nurse faculty members experienced conflicts with staff nurses and other health care providers. The conflicts were related to incorrect nursing procedures and patient advocacy. The dual consciousness as a nurse faculty member and as a practicing nurse created tensions because there were conflicting priorities in the two roles. Faculty felt moral distress during their experiences of disjunctures between practice and education or between what is taught about ethical and best practice in nursing and nursing practice that is found in many clinical practice sites. There were further tensions caused by the necessity to maintain the placements even when the practice was poor and few good role models were

found on the unit. The shortage of clinical placements in the area caused schools to put pressure on faculty to maintain the placements at any cost.

When analysis from an institutional ethnography perspective was carried out, it was clear that the conflicts around nursing procedures and patient advocacy were related to staff nurses' inability to practice as they had been taught due to structural constraints. The dual consciousness tension that faculty members felt related to best practice was also being shaped by the regulatory body's ruling text. Faculty members stated that they would choose to protect patients first, even if they had to push the student aside. The institutional ruling relations are evident in staff nurses' practice, and coercion of students to adopt poor practice in accordance with institutional ruling relations creates the situation in which the faculty members perceive that they are "choosing" the patient over the students because the patient is in jeopardy. Faculty members stated that patients took priority over students, but they accommodated both patients and students and role modeled best practices. Role modeling was also shown to be directed by ruling relation texts.

From the "extralocal" perspective, the shortage of placements was created by neoliberal decisions made at the provincial government level. The decision for staff mix was also made at the provincial level as a cost-containment measure. Both the provincial and federal governments support the managerial accounting focus in health care. The structural issues in the health care system do not allow for best practices or patient-centred care. The hegemonic hierarchical practices remain in the system because that is inherent in the corporate business model.

What was absent or not stated in the narratives was the uneven power relationship between students and faculty. In this study, faculty voice was privileged and student voice

was not addressed. Students may feel unsupported or fearful of faculty and their voice should be heard. This has important implications for future work.

7.2.2 Research Question Two

How do individual nursing faculty members navigate the disjuncture between practice and education?

The narratives in this study illustrate how faculty members deliberately and skilfully navigate practice-education disjunctures with their students. The ruling texts from the regulatory body directed the nurse faculty to try to maintain best practices even in the face of poor practice. The faculty members deliberately cultivated relationships in order to be able to advocate for patients and best practice. During the process of navigation, faculty role modeled good practice, advocated for the patients and cultivated relationships with staff as a way to try to change practice. Post-conferences were seen as important times for debriefing with students about the difference between a school nursing lab setting and the messiness of reality. It also allowed time off the unit for discussion of ethical practice and personal moral distress. Successful navigation of the disjuncture requires the faculty to have confidence in their own nursing role and experience in teaching. Mentorship by experienced faculty members who successfully navigate and advocate for better practice was helpful to new faculty, just as students need good role models in practicing staff nurses. Experienced faculty were able to demonstrate more skilful navigation because they used their experience and resulting confidence to negotiate with staff.

From the everyday institutional ethnography perspective, faculty members were obligated to “dance the dance” because of the need to maintain placements. They had to

cultivate relationships even though there were ruling relations maintaining the hierarchies and placing students at the bottom.

From the extralocal perspective, the structural constraints are affecting the ability of the staff nurses and other health care providers to provide patient-centred care. I believe that the hope that faculty members have that the staff can change by seeing good role models is a false hope. The structural constraints created by the corporatization of the health care system have to be acted upon at a systems and political level.

7.2.3 Research Question Three

How can these stories contribute to nursing curriculum and the preparation of nurses as advocates for change within the health care system?

Awareness and orientation of navigating the practice-education disjuncture for both students and new faculty was widely suggested. Most faculty members were hopeful that teaching students to advocate for patients and for best practice would help change poor practice. Addition of curriculum content on the concept of power and addition of more communication skills around conflict resolution were suggested as ways to empower students. These concepts were also suggested as part of new faculty orientation. Many of the faculty members voiced their awareness of the structural issues and their empathy for nurses working within a system of constraints. However, the power issues need to be acted upon at a systems level. The extralocal ruling relations are maintaining the status quo, and it requires more than empowerment of individual students.

7.2.4 Summary of Findings

The settings in which disjunctures take place are problematic: visible, invisible and hidden power structures are embedded in the care settings. I explored the practice-disjuncture space by beginning with the everyday as problematic. This was evident in the narratives of individual nurse faculty. I explored the social and institutional relations organizing these experiences. I argue that individual nurse faculty experience dual consciousness as nurses and educators. This dual consciousness leads to conflicts with staff, tension and moral distress. In response, faculty exercise some power and agency in a fluid and dynamic way, depending on the context. They employ various strategies to navigate the conflicts. The everyday practice of nurse faculty is embedded in various domains of nursing; the hospital setting has explicit historical rules of hierarchy that individual nurses have consciously and unconsciously acquired in their professional training. Hidden and invisible are the unwritten rules, regulatory texts and ruling relations that reproduce the power structures in the profession of nursing and the hospital settings. The staff nurses must be members of CRNBC in order to practice in British Columbia. Behind the regulatory body, there is provincial legislation, the Health Professions Act, which legislate the mandate of regulatory bodies such as CRNBC. The Health Professions Act is governed within the provincial Ministry of Health.

As depicted in Figure 4, beyond the local setting, there is another layer of regulatory text at the national and the global levels. The Canadian Nurses Association influences the individual nurse at a national level and the health care system is directed by public provincial and national health ministries. The provincial and federal health ministries are political entities guided by the political ideology of the current political party in power. Global interests, because they are supported and maintained by political interests, influence health

care systems. These global interests are the hidden drivers of the corporatization of health care systems; Canada competes at the global level for international trade needed to maintain the level of monetary success that the dominant group in Canadian society has come to expect. There is also the influence of the federal immigration policies which have been created to address shortages of health care providers. An example is the Live-In Caregiver program. Many internationally trained nurses come to Canada as live-in caregivers and when they were unable to gain their Canadian nursing credentials, end up working as care aides.

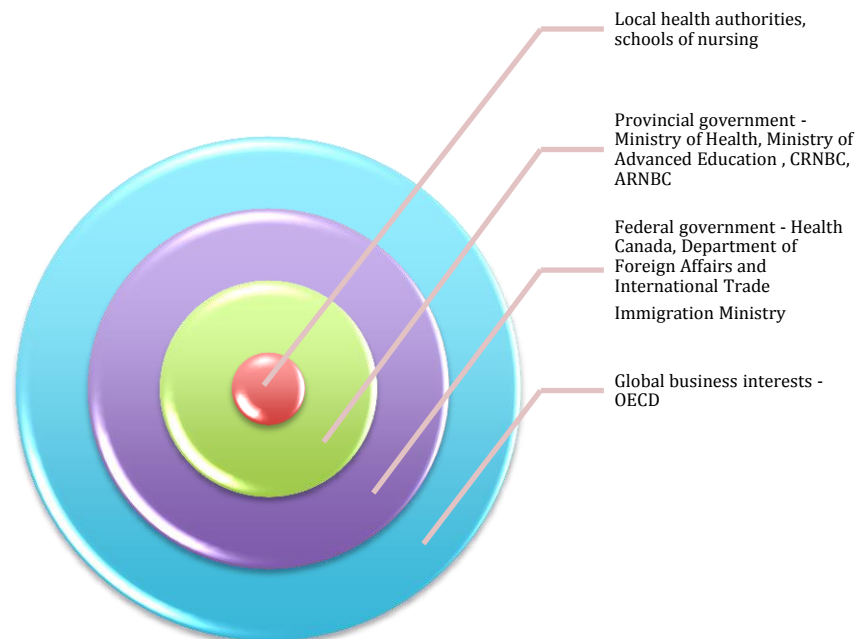


Figure 4. Nested Sets of Relations

Theoretical Considerations

The theoretical perspectives used were social constructivism and critical theory informed by Smith's institutional ethnography. The narratives portrayed the nest of social relations within which faculty members are located. In Smith's notions of power,

coordination is unseen and is in textual forms. In these regulating texts, power is generated and maintained. This notion of ruling relations in text form helped to shed light on aspects of nursing such as the administration of medication and the discomfort of dual consciousness. The need to maintain placements put faculty members in stressful situations. The study of the “extralocal” related to the shortage of placements led to the exposure of the multiple reasons for the shortage of placements. This brings to light the influence of the decisions made by a government with a neoliberal agenda.

The literature review looked at the everyday contexts, which included reality/transition shock, moral distress and incivility. These issues were present in the description of practice-education disjunctures. There is a link to my findings and theory being developed about the relationship between disjuncture and moral distress. The findings from this study contribute to a deeper understanding about the phenomenon of disjunctures and moral distress and warrants further exploration.

The “extralocal” context literature review focused on historical, neoliberal corporate and hegemonic hierarchical influences. All of these influences were used to understand what was happening at the “extralocal” levels. It seems apparent that for any change to take place, action has to be at both the everyday and “extralocal” levels.

7.3 Implications

A key goal of this inquiry was that the findings generated by this study could help nurse faculty and students advocate for change in the health care system. Many of the root causes of poor nursing practice are structural and located in the practice arena (and therefore outside the jurisdiction of education), educators are limited in what changes they can make.

At the same time, however, education can play a key role in supporting those changes by teaching future graduates about the structural dimensions of health care and how they can take up opportunities to inform or to advocate for change in structural problems such as nurse workload and the imperative of efficiency under which nurses must practice. Nurse faculty members at the bedside with their students have a clear view of the practice environment. They can influence others to attend to such issues as workload. Nursing faculty also need to share their experiences and to bring those understandings to increase the awareness of student nurses and of new faculty about these issues. Even as guests, faculty members are in a position to help students to become graduates who are able to speak up and to demand patient and family centred care. Faculty members are also in a position to support staff in resisting the corporatization of health care.

The additions to the nursing curricula and suggested strategies for faculty and students to manage the practice education disjuncture can help to better prepare student nurses and nurse faculty to take action in the face of poor practice. If we want to move closer to the ideal in practice, then the curricular content needs to provide students with tools to advocate for change. Arming the students with some basic understanding of power issues would lead to more reflexive practice by students.

Dorothy Smith's notions could be used to re-think nursing education, not just as a way to critically analyze practice, but also as a way to understand that nursing practice is located in social and structural relations. Using Smith's ideas about ruling relations and the everyday as problematic could help to organize nursing curricula. Smith believes that power is found in texts and language because they coordinate local activities from an institutional level. When hidden and invisible power is made visible, faculty and students can be

empowered and learn strategies for action. The concept of power should be explored early in a student nurse's education because power issues are found in all practice settings. Individual agency may not be enough but collective voices may overcome the constrained agency.

My study suggests that it is not just how student nurses should anticipate disjunctures and what they can do to respond and to be advocates, but also that changes could be made in how the fundamentals of good care are taught. When “ideal” nursing practice is taught in labs and classrooms without addressing the context of practice, it tends to generate some problems later for students. Care should be taken by faculty to teach in a nursing principles-approach rather than teaching “ideal” practice because context needs to be considered in each unique situation. This study also points towards a more dialogical approach that both faculty and students should use in practice with staff, because; some of the examples of effective actions seem to take this approach. In the past, it was assumed that all nurses were taught in the same way but that is no longer true, and engagement and dialogue with staff nurses is necessary to avoid making assumptions that can lead to conflict.

What comes out very strongly in the narratives are the “efficiencies” that indicate the incredible system strains under which nurses are working. The study by Varcoe, Pauly, Storch, Newton and Makaroff (2012), backed by many other studies, verify that there are organizational structural issues that affect nursing practice. They suggest redefining moral distress as a relational concept to provide a better understanding of the dynamics of moral agency and the interplay of the context of practice and power structures. Moral distress emerges as a result of dual consciousness and power imbalances between providers and hierarchies of power that are deeply embedded in health care systems. A multi-pronged approach is needed and strategies for change can be focused at, (a) the structural level (e.g.

nurses' workload), and at (b) the individual level (e.g. avoiding use of hierarchical language). The nurse faculty narratives illustrate their understanding of the constraints of the staff nurses, supporting the view that change is required at structural levels to address workload and staff mix issues. Faculty as guests can bring attention to the struggle that staff face every day. It is apparent that staff have constrained agency and faculty as well as the staff can champion structural changes that are needed.

Faculty do need consistent peer and school support to manage their moral distress. Weekly teleconferences could provide the connection and support by peer faculty and also allow debriefing of the moral distress that new faculty may be facing. As part of the ongoing support, debriefing discussions amongst faculty could include role rehearsal of alternate or different endings of the situations, which caused moral distress. For example, new faculty could role rehearse by practicing what they would say to a staff member who is rude or unwelcoming to students. Additional time will be needed in the orientation of new faculty to discuss the experience and the navigation of the practice-education disjuncture, including discussion of the hidden power issues and advocacy for change in the health care system that will sanction and support best practices and patient-focused care. This will require action at the systems level and in a political arena.

It is also important to consider new models of practice education. There are other practice-education models in other parts of the world. For example, in Australia, staff nurses are responsible for teaching the students on the unit. Faculty members from schools are not assigned to teach groups of students on hospital units. This may be seen as returning to the apprenticeship model which will continue to perpetuate the problematic structures but what I am suggesting is a new model where practice and education work closely together so that

what is taught is practiced and what is practiced is taught. For example, students could spend most of their clinical experience time at one care facility to allow students, faculty and staff to develop reciprocal relationships, that is faculty and students would be adding to quality improvement and unit staff would be providing mentorship to students to become competent professionals. Faculty might also become part of the unit staff so that they are not navigating in a liminal space. This would take agreement between facilities and all schools of nursing in an area. Schools of nursing could partner with provincial bodies: the CRNBC, the Association for Registered Nurses BC and the BC Nurses Union to imagine new models of practice education. Together we can advocate for patient needs to be privileged. The CRNBC accreditation requirements could be updated to reflect the reality of the shortage of placements for clinical experience and assist in the development of a new model for practice education. Practice-education disjunctures are a symptom of larger complex issues and as such, there are no simple solutions. What we do know, is that the current system is not working and change requires both practice and education stakeholders to work together to create a better system of practice education.

As stated before, the Health Professions Act establishes a legal duty for nurses to report situations in which a health professional's practice is impaired or incompetent and may pose a significant risk to the public. There should be an additional requirement to report poor working conditions that impairs a health professional's ability to provide quality practice or the act re-interpreted to include a focus on how working conditions lead to poor care and safety concerns.

Finally, there are implications for the education of nurse leaders, related to the call by Laschinger, Wong, and Grau (2013), for theory-driven, relationship-oriented leadership

strategies and the recommendation by Hutchinson and Hurley (2013), for an emotional intelligence informed leadership to mitigate bullying or incivility in the workplace. Nurse leaders with this educational grounding will be more effective in creating and sustaining the desired structural changes.

7.4 Limitations of the Research

This research project has uncovered the everyday experience of nursing faculty and the negotiations they employed to navigate the clinical experience with their students. The project has generated strategies for faculty and students for successful navigation of a practice-education disjuncture. It is delimited by the specific contexts of their practice: they were in different clinical settings but all located in a large urban area. Thus, their experiences may not be transferable to the contexts of nursing faculty working in smaller rural settings. For example, there may not be the same number of students, patients and staff nurses from cultures other than the dominant Euro-Canadian groups. In more rural settings, group dynamics may be different because staff nurses may be well-known to students and faculty, creating a different social dimension to be addressed. Also in non-urban areas, there may not be the same shortage of placements including maternity and pediatric areas. As such, faculty members would not be under the same pressures to maintain the placement.

Another limitation to note is the retrospective dimension of this study, based on what the participants recollect of a past experience — some details may have been forgotten. As well, my identity as a fellow nurse faculty may have led some participants to give me stories that they perceived I wanted. Being part of the “tribe” may have led to assumptions in my interpretation because many of the narratives seemed as they were shared experiences across many faculty, although another interviewer without a nursing background might have

interpreted things differently. During the interviews, I did deliberately ask for clarification of the interviewees on details of the narrative to try to overcome the danger of “insider” assumptions. For example, I did make an assumption that disjunctures were uncomfortable, but when I asked one of the community care nurses about this, it turned out that she was not uncomfortable. It was expected that there would be some disagreements between practice and education, and this faculty member was able to adapt to the situation and was not upset by the disjuncture. However, on reflection, I wonder if it was because she had a longstanding relationship with the clinical unit and was able to create a level of trust that allowed for this.

For some interviewees, narrating their experiences of disjunctures was emotional and despite time having passed, narrating their experiences still engendered a stress response. As the interviewer, I sometimes felt I had to intervene by creating space to allow for pauses and that could have somewhat changed the narrative.

Finally, this study is focused on faculty and excludes other players such as, students, patients, and staff. While a focus on one group allows an in-depth look of that specific group, it is also a limitation in that study of the other stakeholders would have provided a more complete picture.

7.5 Future Research

In future research, a focus on student perspectives would help create a better understanding of how students experience and navigate the practice-education disjuncture. This could contribute to a more complete picture of the practice-education disjuncture. Future research could also engage with staff nurses and even patients, adding another dimension and contribution to deeper understanding of these disjunctures.

The participants were from different schools of nursing but in a geographically contained urban area. There may be different findings with faculty from different areas and different settings. In this study, there were several settings; focusing on one practice setting (such as community) and comparing it to another practice setting (such as an acute care hospital setting) would contribute more understanding of the complexity of the location of disjuncture.

In future research interventions, such as having faculty brainstorm about alternate endings to the narratives and being invited to engage in rehearsal and trial of different endings and versions of their narratives, could be studied for effectiveness.

Another suggestion for research is examining the relationship between students and care aides because there is little written about care aides, and they are increasing in numbers. There is literature from the United Kingdom, which attests to care aide influence on student nurses (Spilsbury & Meyer, 2005). Because many care aides are doctors and nurses from countries other than Canada, further research could be related to “extralocal” issues at a federal level such as immigration policy and nurse migration.

Finally, future research could more explicitly investigate how race, gender and class differences operate in the conflicts within the experience of practice-education disjunctures.

7.6 Conclusions

The results confirmed for me that the practice-education disjuncture was a challenging liminal space for faculty, one shaped by broader systemic power imbalances where nurses and other caregivers have little power to provide good care. Adding to the complexity is the continuing historical reproduction of power inequities. The care settings in

which nurses work have been greatly affected by the managerial approach to healthcare and individual nurse agency has been constrained. I was surprised by how deliberate and strategic the process was that faculty used to navigate through disjunctures. They also teach this navigating process to students so that they can use the process when they are caught in disjunctures as new graduate nurses. While a deliberate teaching of the process has limited impact on the structural issues of the health care system, new graduates armed with an awareness of the complexity of the issues constraining nurses may be more able to champion change.

This study has changed my practice as an educator because I realize now that the orientation for new faculty must be considerably more than spending a few hours with a staff nurse and with the last clinical instructor on that specific unit. It has to be much deeper than orientation to the forms, the evaluation tool, the instructor package, the weekly teleconferences and an introduction to the e-learning platform. New faculty members should have an understanding of the navigating process through disjunctures. They need to have peers who will listen to the moral distress from the experiences of practice-education disjunctures, and they need to fully develop their relational skills to skilfully navigate the disjunctures. Faculty and students can make a difference as Rankin and Campbell (2006) state:

...Education is an important site of opposition to the erosion of nurses' judgment; and it is important to remember that even under contemporary methods of management, hospitals are still substantially reliant on nurses' judgment. This is the stage upon which nurses' oppositional work can be performed on behalf of their patients. ...Nurse educators persuaded by our analysis are well positioned to

develop curricula to offer students analytic skills to question, 'Whose knowledge are we authorizing?' 'In whose interests does this knowledge work?' 'What knowledge does it displace?' (p.177-178)

Initially, I thought that nurse faculty members had no clear-cut entry point to make changes, but they can work with the students to raise their awareness of the structural changes that are needed. Sewell (1992), describing his theory of structure, defines “structure” as “*mutually sustaining cultural schemas and set of resources that empower and constrain social action and tend to be reproduced by that action.*” (p.27). He argues that structure is dynamic and is continually evolving as a result of social interactions; agency can sustain and reproduce the structures but can also transform structures. This speaks to the hope that change can happen if the agency of students and faculty is strengthened and collaborative action can be taken.

There is hope for changes in the system with collective action. The “*something out there that's more powerful than we are*” can be tackled.

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Appendix A

Interview Questions

Interview questions for faculty members who are clinical instructors:

1. Please tell me a bit about your nursing career and experience as a faculty member?
2. Can you tell me about an occasion where you led a group of nursing students in a clinical experience and you found that there was a disjuncture about what had been taught as ethical and best practice at school and the actual practice found at that particular clinical agency?
3. How did these encounters with such disjunctures make you feel? What were you thinking at the time and what actions did you take? Please provide as much detail as possible about these moments and how you navigated through the situation as a nurse.
4. Can you describe more about how the students navigated the situation? What did they feel, think and do in response to the situation? How did you respond to your students in these situations?
5. How do you think nursing faculty and nursing programs should respond to these recurring situations? What do you think are the implications for nursing curriculum, planning and organizing clinical placements? What should we as nursing faculty teach students nursing about these encounters? What are the implications for curriculum?

Questions for faculty members who are placement coordinators

1. Please tell me a bit about yourself, particularly your nursing career and work history in nursing education?
2. Can you tell me in detail of a situation in which the faculty complained about a clinical setting because of the practice-education disjuncture?
3. Can you describe what happened with the placement? If it was not changed, how did the faculty and students handle this?

4. Can you describe the follow-up with clinical agencies about the situation of practice-education disjuncture?

Appendix B

Invitational Letter

THE UNIVERSITY OF BRITISH COLUMBIA



Department of Educational Studies

Mailing address:

2125 Main Mall

Vancouver, B.C. Canada V6T 1Z4

Tel: 604-822-3897

Fax: 604-822-4244

<http://www.edst.educ.ubc.ca>

Invitation Letter

May 8, 2011

Hello, my name is Katherine Fukuyama. I am a member of the nursing faculty at Vancouver Community College and a doctoral candidate in the EdD program in the Department of Educational Studies at UBC. My doctoral research supervisor is Dr. Shauna Butterwick. I am writing to ask you if you would be interested in participating in my doctoral research, the purpose of which is to gather stories from nursing faculty about their experiences of the practice-education disjuncture and to identify how nursing curriculum and nursing faculty can more effectively respond to these difficult experiences. The practice-education disjuncture refer to those times when there is a disjuncture about what had been taught as ethical and best practice at school and the actual practice found at that particular

clinical agency. I am hoping to speak to those who are relatively new in their nursing faculty roles, as well as those with many years of experience of supervising student nurses in their clinical and practice settings.

I am collecting data for this research project through two methods: individual interviews and group interviews. With permission, the individual and group interviews will be tape recorded. Individual interviews will take about one hour during which time I will ask participants to tell me some stories about their experiences of the education-practice disjuncture, what they thought, how they felt and how they responded. After doing an initial analysis of the individual interviews, a summary of the stories and themes will be sent to participants for confirmation and comment. Building on these stories and themes, group interviews lasting about two hours, with about 6 to 8 participants, will be held to discuss some of the themes and stories emerging from the interviews and to explore implications for nursing curriculum and related policy. A summary of the themes from the group discussion will be sent to participants; a summary of the findings of the study will also be provided to participants.

Study participants' names and identities or institutional affiliations will not be revealed. Data will be assigned a code and that information will be kept in a password protected computer file. Other than my research supervisor, Dr. Butterwick, no other persons will have access to the study data. Your participation in this study is entirely voluntary and you can refuse to participate or withdraw from the study at any time without jeopardy. There

are no anticipated risks to this study. If you are interested in participating, please contact me via email or phone. Thank you for considering this invitation to participate.

Kathy

Appendix C

Informed Consent

THE UNIVERSITY OF BRITISH COLUMBIA



Department of Educational Studies

Mailing address:

2125 Main Mall

Vancouver, B.C. Canada V6T 1Z4

Tel: 604-822-3897

Fax: 604-822-4244

<http://www.edst.educ.ubc.ca>

Consent Form

How Do Nursing Faculty Navigate Conflicts and Tensions Within The Disjuncture of Education and Practice?

Principal Investigator: Dr. Shauna Butterwick, Associate Professor, Department of Educational Studies, UBC,

Co-Investigator(s): Katherine Fukuyama, Graduate student, Department of Educational Studies, UBC

Purpose:

I am interested in learning more about your experiences in relation to how you navigate the conflicts and tensions when faced with a disjuncture of practice and education. I will be using this interview with you as part of my doctoral dissertation. The purpose of this narrative study is to explore how nursing faculty make meaning of their experiences of the disjuncture or gap between what is taught about best practice in nursing schools and nursing practice found in many clinical practice sites that do not meet these standards. The goal of

this exploration is to point to some educational and action oriented interventions for faculty and students to navigate in the liminal space of the practice education intersection. With a better understanding of the experience, nursing faculty can help students to navigate the whirlpools of practice more skilfully. You are being invited to take part in this interview because of your experience in taking students to clinical settings.

Study Procedures:

I will be conducting individual and group interviews in a mutually agreed upon location that is convenient for you although it is best to avoid noisy cafes where it is hard to hear tape recordings and hard to maintain confidentiality. I will be asking you to tell me about an occasion where you led a group of nursing students in a clinical experience and you found that there was a disjuncture about what had been taught as ethical and best practice at school and the actual practice found at that particular clinical agency and how these encounters with such disjunctures affected you and the students. The interview will take approximately one hour of your time. It will be audio-taped (with permission). I will also ask you to forward the invitational letter to nursing colleagues in your institution whom you think would be interested in participating in the study (and who fit the criteria). If you wish, a copy of the tape and/or transcription will be provided to you. Building on these stories and themes, group interviews lasting about two hours, with about 6 to 8 participants, will be held to discuss some of the themes and stories emerging from the interviews and to explore implications for nursing curriculum and related policy. A summary of the themes from the group discussion will be sent to participants; a summary of the findings of the study will also be provided to participants.

Potential Risks:

There are no anticipated risks for participating in this interview.

Potential Benefits:

Faculty may become more self-aware of the strategies that they have used to manage in the disjuncture. There may also be some benefit from participating in a study of an issue in nursing education that concerns faculty and contributing to the development of curricular resources.

Confidentiality:

All documents and recordings will be identified only by code number and kept in a locked filing cabinet. Names of people, locations and any other data that may lead to identity of persons or places will be transcribed to maintain confidentiality, for example, “*person x at location y.*” Electronic data records will be kept on a password-protected desktop computer. Password will be only known to the researcher.

Remuneration/Compensation:

Participants will be provided coffee and snack at the interview.

Contact for information about the study:

If you have any questions or desire further information with respect to this study, you may contact Katherine Fukuyama or the research supervisor, Dr. Shauna Butterwick.

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 604-822-8598 or if long distance e-mail to ORSIL@ors.ubc.ca.

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.

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 of subject

Appendix D

Affiliation Agreement

EDUCATIONAL INSTITUTION AFFILIATION AGREEMENT TEMPLATE

BETWEEN:

[Name]

Address: ☐

Phone: ☐

Fax: ☐

Title of Representative:

("Health Authority")

AND:

[Name of Educational Institution]

Address: ☐

Phone: ☐

Fax: ☐

Title of Representative:

("Institution")

BACKGROUND:

The Health Authority and the Institution wish to work together to support the learning experiences of students enrolled in the Institution's educational programs, by providing them with access to practice education experiences at one or more facilities operated by the Health Authority.

AGREEMENT:

The Health Authority and Institution agree to be bound by the attached Terms and Conditions (“Agreement”). This Agreement may be executed in counterpart, both of which together will constitute one and the same instrument and either party may deliver an executed counterpart by facsimile transmission.

BY SIGNING BELOW THE PARTIES AGREE TO BE BOUND BY THIS
AGREEMENT:

HEALTH AUTHORITY

INSTITUTION

Per:

Per:

Authorized Signatory

Authorized Signatory

Name:

Name:

Title:

Title:

Date:

Date:

TERMS AND CONDITIONS

1. DEFINITIONS

In this Agreement:

(a) “Applicable Law” means all present and future laws, statutes and regulations, applicable to any person, property or event relating to this Agreement, and all directives, rules, guidelines, orders and policies of any governmental authority having authority over that person, property or event and all general principles of common law and equity.

(b) “Business Day” means a day other than a Saturday, Sunday or statutory holiday in British Columbia.

(c) “Confidential Information” means all data, information and material relating to the Health Authority and its services, HA Staff, contractors, service providers or Patients, whether or not it is stored in written, electronic or any other form, that Students or Institution Staff receive, in connection with this Agreement, including

(i) Personal Information about HA Staff and Patients,

(ii) Health Records,

(iii) any information about the business, affairs or operations of the Health Authority which is not generally known or available to the public.

(d) “Facilities” means those facilities that are operated or administered by the Health Authority.

(e) “FOIPPA” means the Freedom of Information and Protection of Privacy Act (British Columbia), and regulations thereto, as amended or substituted from time to time.

(f) “HA Staff” means the officers, directors, employees, physicians, contractors, subcontractors, representatives or agents of the Health Authority.

(g) “Health Care Services” means all services provided by the Health Authority to or for the benefit of members of the public whether in acute, residential care, community care, research or other sectors.

(h) “Health Records” means Patient care records, clinical records and all other records and documents pertaining to the delivery of Health Care Services to Patients or Patient Personal Information.

(i) “Health and Safety Standards” means all Applicable Laws, standards of practice and codes of ethics issued by any professional regulatory body, and all rules, policies and regulations in place at the Health Authority or its Facilities that apply to the Students or

the Institution Staff at the Facilities, any of which relate to workplace safety, the delivery of Health Care Services or the health and safety of Patients or HA Staff.

(j) “Institution Staff” means the instructors, officers, directors, employees, contractors, subcontractors, representatives or agents of the Institution.

(k) “Patients” means individuals who receive Health Care Services from the Health Authority or at the Facilities.

(l) “Personal Information” has the meaning set out in FOIPPA;

(m) “Practice Education” means that part of a student’s educational experience which takes place in the workplace and may involve direct patient care or access to patient information. In such an experience, the student may provide services to and for the benefit of patients/families. The student provides such services under the general direction and supervision of HA Staff or Institution Staff, who are practicing health professionals, and are authorized and qualified to provide the services.

(n) “Program” or “Programs” means those educational programs offered by the Institution and recognized by the Health Authority.

(o) “Students” means those students of the Institution who are selected by the Institution to participate in the Programs.

2. SCHEDULES

Schedule A (Insurance) attached to this Agreement, will, for all purposes, form an integral part of this Agreement.

3. Term CHOOSE OPTION 1 OR 2

OPTION 1 – TIME LIMITED:

This Agreement will commence _____, 20__ and shall continue for a period of _____ year(s) _____ month(s) to _____, 20__ unless terminated earlier in accordance with Section 11. The parties shall review this Agreement from time to time and revise if necessary by mutual agreement. The parties may agree, in writing, to renew this Agreement for further periods of one or more years/month(s).

OPTION 2 – ‘EVERGREEN’:

This Agreement will commence _____, 20__ and shall continue thereafter until terminated in accordance with Section 11. The parties shall review this Agreement from time to time and revise if necessary by mutual agreement.

4. MUTUAL OBLIGATIONS AND ACKNOWLEDGEMENTS:

(a) The Health Authority and the Institution agree:

(i) to work collaboratively with each other to enhance the practice education experience of the Students in the Programs;

(ii) to promote inter-professional practice education planning, delivery and evaluation;

(iii) to comply with the provisions of this Agreement and all Applicable Laws in the delivery of the Program.

(b) The Institution and the Health Authority acknowledge that the Students’ educational program is designed and sponsored by the Institution, and the Institution acknowledges that the Health Authority provides no representations or warranties concerning the practice education experiences or its ability to provide supervision of or instruction to Students.

5. OBLIGATIONS OF THE HEALTH AUTHORITY:

(a) The Health Authority agrees:

(i) to provide Institution Staff and Students with reasonable access to Facilities for the practice education experience and to provide supplies and equipment as reasonably required to support the practice education experiences; and

(ii) to provide such onsite supervision of Students engaged in the practice education experience at the Facilities, as may be agreed upon with the Institution;

(iii) to make available to the Student, and to the Institution Staff, the Health and Safety Standards, any applicable intellectual property policy, and such other of the Health Authority's rules, regulations and policies that apply to the Program;

(iv) to consult with the Institution in its evaluation of the Programs when reasonably requested to do so;

(b) Notwithstanding any other provision of this Agreement, the Health Authority's obligations under this Agreement will be subject to the availability of resources, its operational and administrative needs and ensuring the safety and care of its Patients. Without limiting the foregoing, the Health Authority may, at its discretion, alter, change, re-schedule, substitute or terminate any Program or any practice education experience in order to meet its operational or administrative needs, in the event of employment or labour disputes or disruptions, to comply with Applicable Laws, in the event of emergencies or on the basis of the health or safety of Patients and HA Staff.

6. OBLIGATIONS OF THE INSTITUTION:

(a) The Institution agrees:

(i) to work collaboratively with the Health Authority to ensure the effective operation and administration of the Programs, including scheduling the practice education experience and instruction for Students and attendance by Institution Staff;

(ii) to ensure all Students are duly registered at the Institution, are in good standing and satisfy all of the Institution's admission and performance standards necessary for participation in the Programs;

(iii) to work with the Health Authority to designate HA Staff and/or Institution Staff who will be engaged in planning of the practice education experience and instructing Students in the course of the Program;

(iv) to consider, and where appropriate, recognize significant involvement of members of HA Staff in the Program through academic appointments to the Institution, subject to the Institution's policies and procedures;

(v) to take reasonable steps to ensure that the Students and Institution Staff are aware of and comply with this Agreement, conduct themselves professionally and courteously, and that they comply with the Health and Safety Standards, any applicable intellectual property policy, and all other rules, regulations, and policies of the Health Authority that apply to the Program;

(vi) to acknowledge that the Health Authority may refuse to permit a Student or member of Institution Staff to attend at any of the Facilities if a student refuses to comply with the Health and Safety Standards, including any testing or screening requirements of the Health Authority; and (vii) that the Institution is solely responsible for the operation of the Programs, and the form of instruction, design and delivery of educational services to Students participating in a Program or Programs.

(b) The Institution agrees that it is an independent body, and not the agent, partner or joint venturer of the Health Authority and the Institution will not hold itself out to the public as

such or make representations to Students or others that the Health Authority has approved the Programs.

- (c) The Institution will take all reasonable steps to ensure that all Students and Institution Staff are aware and understand standards of work place behaviour, including but not limited to, harassment, discrimination, sexual misconduct, abuse, and appropriate professional and respectful work place behaviour, confidentiality, all consistent with Health Authority practice education policies and guidelines and other rules, policies and standards.

7. DESIGNATED REPRESENTATIVES, INCIDENT REPORTING & DISPUTE RESOLUTION

- (a) In respect of the Program or Programs, the Health Authority and the Institution will designate one or more individuals to act as their respective representative(s) in all matters relating to the operation of the applicable Program or Programs, in order to facilitate communications between the parties to this Agreement.
- (b) The Institution will immediately report to the Health Authority any incident taking place at the Facilities involving its Students or Institution Staff that causes or compromises the mental or physical health or safety of Patients, HA Staff or members of the public, including, but not limited to, breaches of the Health and Safety Standards.
- (c) If the Institution identifies a Student or Institution Staff member who poses or may potentially pose a health or safety risk to HA Staff or Patients at the Facilities, the Institution will immediately advise the Health Authority, and will, if reasonably necessary to protect others, suspend that Student's or Institution's Staff member's participation in the Program, which may not be resumed without Health Authority approval.

(d) The Institution and the Health Authority will make good faith efforts to resolve any dispute related to this Agreement by amicable negotiations. All claims, disputes or issues in dispute between the parties that are not resolved by negotiation will, with the agreement of the parties, be decided by mediation or arbitration, or failing agreement, in a Court of competent jurisdiction within the province of British Columbia.

8. SUSPENSION AND REMOVAL

(a) The Health Authority may suspend or exclude a Student or an Institution Staff member from Program activities at the Facilities, either temporarily, pending investigation or permanently, in any circumstances where the Health Authority or Institution has identified that the Student or Institution Staff member has, or there are reasonable grounds for believing that the Student or Institution Staff member has:

(i) failed to comply with the Health and Safety Standards or any other rules, regulations and policies of the Health Authority or any agreement with the Health Authority;

(ii) endangered the mental or physical health or safety of any person; or

(iii) otherwise interfered with or compromised the operation of the Facilities or the provision of Health Care Services.

9. EMPLOYMENT

The Institution agrees that the Institution Staff and Students are not, by virtue of their involvement or participation in the Programs, employees of the Health Authority, nor are they entitled to employment benefits of any kind whatsoever from the Health Authority, including but not limited to statutory programs and disability, life or other insurance coverage. The Health Authority will have no liability or responsibility for the withholding,

collection or payment of income taxes, employment insurance, statutory or other taxes or payments of any nature on behalf of, or for the benefit of, the Institution, Institution Staff or the Students. The Health Authority shall be solely responsible for the employment, working conditions and any liabilities arising from its employment relationship with HA Staff participating in the Programs. For further clarification, this provision does not limit the Health Authority's ability to hire Students independently of their participation in the Programs.

10. PRIVACY AND CONFIDENTIALITY

- (a) It is acknowledged that in the course of participating in the Programs, Institution Staff and Students may have access to Confidential Information, and that such information is subject to obligations of privacy and confidentiality. More particularly, the Institution acknowledges and understands that the Health Authority is a public body subject to the provisions of the FOIPPA and owes obligations of privacy and confidentiality to, among others, Patients and HA Staff.
- (b) The Institution acknowledges and agrees that all Confidential Information is deemed to be the property of the Health Authority, and that this Agreement does not grant the Institution, Institution Staff or Students any authority to use, disclose, collect or retain such information or records except to the extent strictly required for participation in a Program. Without limiting the foregoing, in no case will Students or Institution Staff be permitted to retain or remove Health Records from the Facilities without the express written consent of the Health Authority.
- (c) The Institution agrees that:

(i) it will take reasonable steps to ensure that all Institution Staff and Students are aware of and uphold Health Authority policies regarding privacy and confidentiality and comply and act consistently with the Health Authority's obligations under the FOIPPA and any other Applicable Laws or standards of practice;

(ii) it will immediately report to the Health Authority any breaches or potential breaches of this paragraph 10, and provide assistance and cooperation with any investigation conducted by the Health Authority into such breach; and,

(iii) on request, it will immediately return any Health Records or Confidential Information in the possession of the Institution, and will use its best efforts to facilitate the return of any Confidential Information in the possession of Institution Staff or Students.

(d) The Institution acknowledges that this Agreement requires the Institution to make disclosure of certain information about Students and Institution Staff to the Health Authority. The Institution shall obtain all necessary consents from Students and Institution Staff, including under the Personal Information Protection Act or the FOIPPA, as applicable, to permit such disclosures.

(e) The Health Authority shall protect the Personal Information of Students and Institution Staff that is in the custody and control of the Health Authority all in accordance with FOIPPA.

(f) No Student will be permitted by the Institution to participate in a Program unless he or she has signed a Confidentiality Agreement in a form approved by the Health Authority.

11. TERMINATION

(a) This Agreement or any one or more Programs may be terminated as follows:

(i) by either party with or without reason, on 90 days' written notice;

(ii) by the Health Authority in the event that the Institution is in breach of this Agreement and the Institution has failed to rectify such breach upon being given 14 Business Days written notice of the breach; or,

(iii) by the Health Authority with immediate effect if the Health Authority determines, in its sole discretion, that a breach of this Agreement has been committed by the Institution and such breach has caused or is likely to cause an adverse effect on the health or safety of its Patients.

(b) Termination will not affect the obligations of either party with respect to any act, omission or event that occurs prior to the end of the effective date of termination.

12. INDEMNIFICATION

a. The Institution shall indemnify and save harmless the Health Authority from and against all claims, demands, losses, damages, judgments, costs, liability, expenses (including reasonable legal fees and expenses), actions and other proceedings made, incurred, sustained, brought, prosecuted or threatened to be brought or prosecuted that are based upon, occasioned by or arising out of any act or omission, error, deed or other matter on the part of the Institution, Institution Staff, or Students arising out of this Agreement, excepting always liability arising from the independent negligence of the Health Authority or HA Staff.

b. The Health Authority shall indemnify and save harmless the Institution from and against all claims, demands, losses, damages, judgments, costs, liability, expenses (including reasonable legal fees and expenses), actions and other proceedings made, incurred, sustained, brought, prosecuted or threatened to be brought or prosecuted that are based upon,

occasioned by or arising out of any act or omission, error, deed or other matter on the part of the Health Authority arising out of this Agreement, excepting always liability arising from the independent negligence of the Institution, Institution Staff, or Students.

13. INSURANCE

The Institution and the Health Authority each agree to maintain insurance coverage in accordance with Schedule A to this Agreement.

14. GENERAL

- (a) This Agreement shall be for the benefit of and be binding upon the parties hereto, their respective successors and permitted assigns.
- (b) If any provision of this Agreement is unenforceable or invalid for any reason whatever, such unenforceability or invalidity shall not affect the enforceability or validity of the remaining provisions of this Agreement and such provisions shall be severable from the remainder of this Agreement.
- (c) The provisions herein and Schedules hereto constitute the entire agreement between the Parties hereto and supersede all previous expectations, understanding, communications, representations and agreements, whether verbal or written, between the parties with respect to the subject matter hereof.
- (d) Any inconsistency between this Agreement, and the policies, guidelines, Schedules or documents appended to or incorporated by reference into this Agreement will be resolved in favour of the Agreement.
- (e) The failure by either party at any time to require strict performance by the other, of any term or provision of the Agreement shall not constitute a waiver or breach of such or any

other term or provision of this Agreement, nor shall it constitute a waiver of any succeeding breach of any other term or provision.

(f) No amendment to this Agreement shall be enforceable unless the same is in writing and signed by the Parties hereto.

(g) This Agreement shall be governed by and construed according to the laws of the Province of British Columbia and the laws of Canada applicable therein, and the parties agree to attorn exclusively to the jurisdiction of the courts of British Columbia.

(h) The Institution may not assign its rights under this Agreement.

(i) Paragraphs 10, 11, and 12 will survive the termination of this Agreement.

(j) Each notice to a Party must be given in writing. A notice may be delivered by hand or fax to a representative of the Party at the address or facsimile number set out on the first page of this Agreement, and will be validly given if delivered on a Business Day to the above address, or, if transmitted on a Business Day by fax addressed to the other Party : [Insert Fax Numbers] or to any other address, fax number or representative that the party designates in writing. Any notice if validly delivered, will be deemed to have been given when delivered.

(k) Any party may deliver an executed copy of this Agreement by fax but that party will immediately dispatch by couriered delivery to the other parties an originally executed copy of this Agreement. This Agreement and all documents contemplated by or in connection with this Agreement may be executed and delivered in any number of counterparts with the same effect as if all parties had signed and delivered the same document and all counterparts will be construed together to be an original and will constitute one and the same agreement.

SCHEDULE A – INSURANCE

1. UCIPP

If the Institution is covered by the University, College and Institution Protection Program (“UCIPP”), the Institution will maintain third party liability coverage through UCIPP throughout the term of the Agreement.

2. Non-UCIPP

If the Institution is covered by an insurance carrier other than UCIPP, the Institution will:

- (a) Maintain comprehensive third party liability insurance in the minimum amount of \$5,000,000 (Cdn) per occurrence, and
- (b) Maintain medical malpractice and/or professional liability insurance in the minimum amount of \$5,000,000 (Cdn) per occurrence covering claims brought against the Institution, Institution Staff or Students who are involved in the Program for injury to or death of a person or damage to or loss of property caused by any negligent act or omission of the Institution, Institution Staff, Students, and its agents or volunteers while in attendance at the Facilities.

3. INJURIES TO STUDENTS AND INSTITUTION STAFF

The Institution will arrange coverage under the Workers Compensation Act (BC) or equivalent coverage for Institution Staff and Students while engaged in activities at the Facilities, or, with respect to Institution

Staff who are contractors or sub-contractors, will arrange and / or require such coverage

4. GENERAL

- (a) The Institution will provide proof of insurance coverage upon request by the Health Authority.
- (b) The Institution will not cancel or materially alter its insurance coverage without thirty days prior written notice to the Health Authority.
- (c) The foregoing insurance will be primary and not require the sharing of any loss by any insurer of the Health Authority.

5. HCPP COVERAGE

The Health Authority is covered by the Health Care Protection Program (“HCPP”); the Health Authority will maintain third party liability coverage through HCPP throughout the term of the Agreement.