

AN EXAMINATION OF NURSES' PRACTICAL JUDGMENTS ABOUT THE
COGNITIVE FUNCTION OF HOSPITALIZED OLDER PEOPLE

by

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Abstract

Nurses' understandings of older patients' cognitive function are central to how they determine and enact nursing care of older people in hospital, however, it remains unclear how nurses develop these understandings. The nursing literature concerned with how nurses determine actions in practice has begun to shift from instrumental views of reasoning to recognition that judgments are based on complex knowledge and are embedded in the particular context of nurses' work. This study aimed to make explicit the complex, situated practical judgments of nurses about the cognitive function of older people in hospitals.

The conceptual foundation of the study was informed by an integration of Aristotle's notion of phronesis and Foucault's understanding of power. A focused ethnographic study was conducted on two units in an urban general hospital over one year. Data were collected from 21 nurse informants through observations and interviews, and an analysis of documents used in their practice. Data analysis was guided by an analytic framework reflective of the conceptual framework.

The findings showed that practical judgments about the cognitive function of older patients in hospital were structured through social relations, and nurses worked within that structure toward a complex understanding of patients' cognitive function that would enable them to improve the situation of patients. Furthermore, ensuring safety and physiological stability emerged as the goals of nursing care related to the cognitive function of older patients and provided direction for practical judgments, including what evidence was sought and how it was used in deliberations about action.

This articulation of nurses' practical judgments about the cognitive function of older patients in hospital is a foundation for further inquiry into the context of nursing practice, educating new nurses on the complexity of nursing judgments and examining policy related to the structures guiding acute care nursing.

Preface

This project was completed by E. Moody, the author, and is original and unpublished.

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Project Title: Understanding how nurses judge cognitive function: A description of acute care nursing practice with older people

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Chapter 1: Introduction

Changes in cognition have long been associated with aging, and with the large proportion of older people¹ in hospital² set to continue growing, the cognitive function of older people is of great significance to those working in hospital. Examining how nurses understand cognition in older patients³ is essential to advance knowledge on how to best care for this population. This study will contribute to gerontological nursing knowledge by examining how nurses in acute care understand their patients' cognitive function through *practical judgments*. Practical judgments are used to guide action in practice, include a broad understanding of evidence, and reflect the context of nursing practice. I argue that there has not been sufficient articulation of how nurses make such judgments about the cognitive function of older patients in acute care, in part because the nursing literature tends to focus on the development, evaluation, and promotion of cognitive assessment tools that adhere to a limited technical-rational model of reasoning. This focus has oversimplified how nursing practice related to judging cognitive function in acute care is portrayed in the literature and has contributed to a dearth of literature

¹ There is much debate about what term will adequately describe the population of interest to this study. I have chosen to use the term “older people” because it is common in the literature and seems to have fewer negative implications (Coudin & Alexopoulos, 2010). There are however, still differences in the age cut-off for this group; 65 years is common but other age cut-offs are used.

² Hospitals or acute care settings are a particular type of health care institution that provides short-term health care for an episode of illness or injury. Patients admitted to hospital are expected to be discharged once they have been treated and their condition is improved.

³ I will use the term “patient” to refer to people who are admitted to hospital. This term has been criticized for situating health care professionals in an authoritative position in relation to the people they care for (Cheek, 2004; Malloy, Hadjistavropoulos, Douaud & Smythe, 2002; Towle et al., 2010). It is used here to differentiate those admitted to hospital from others who may be present in the hospital but are not the focus of care.

exploring how judgments about cognitive function reflect the particular situation of patients, and the realities of nursing practice in the acute care context. In order to develop a more nuanced understanding of nurses' practice around how they judge older patients' cognitive function in acute care, it is important to take a broad approach to examining the issue that acknowledges the complexity of nurses' practice and the diverse knowledge used in deliberations. In this study, I sought to accomplish such an endeavour by conducting a focused ethnographic study of nurses' practice related to judging the cognitive function of older people in hospital.

Having a contextual, in-depth understanding of how nurses are making judgments about their older patients' cognitive function in acute care will provide a foundation for possible advancement in gerontological nursing scholarship around nurses' understanding of cognitive function. This study will challenge assumptions in current scholarship about how nurses come to understand their older patients' cognitive function through an articulation of the highly nuanced knowledge about cognitive function that nurses use to determine their actions in practice. Using focused ethnographic methods has enabled a unique perspective on how nurses judge cognitive function, including how social relations structure their judgments and how socially constructed goals guide their actions.

Background

The care of older people is a significant part of acute care nursing practice. Indeed, the care of older people has been described as the core business of health care (Cheek, 2004; Croucher, 2010). In Canada, older people over 65 years account for 40% of acute care hospital stays (Canadian Institute for Health Information, 2011). The numbers of older people in acute care will likely increase, as demographic trends show

that the proportion of older people in the general population is growing. Currently, older people account for 15.3% of the Canadian population, and by the year 2063 it is estimated this will increase to 25% (Statistics Canada, 2014). These numbers support the need for research to better understand the care of older people in hospital, as nurses will continue to work with many older people in acute care in the future.

One area that receives a great deal of attention in relation to older people is their cognition. Cognition is understood as one aspect of overall mental function; it is a term used to describe many processes that relate to thinking and knowledge, such as attention, orientation, level of consciousness, memory, concentration, judgment and abstract reasoning. Scholars have noted changes in cognition associated with aging as early as the time of Plato and Aristotle (Berchtold & Cotman, 1998; Karenberg & Förstl, 2006) and cognition continues to be a central issue for older people.

Health care literature tends to be focused on cognitive impairments, or conditions with symptoms that include damaged or weakened cognition in older people, including conditions such as dementia, delirium and depression. The focus on cognitive impairments has been particularly pronounced in literature exploring the care of older people in hospital where the high prevalence and incidence of such conditions have been reported. The Canadian Coalition for Seniors' Mental Health reports delirium rates of up to 50% and depression rates of up to 21% in hospitalized older people in Canada (2006). Likewise, more recent studies from countries with demographic and health care characteristics similar to Canada report comparably high rates of cognitive impairments in hospital. In one Irish hospital, for instance, the prevalence of delirium was found to be 20.7% in hospital patients of all ages, and much higher on geriatric units (53.3%) (Ryan

et al., 2013). A study from Australia identified rates of delirium in patients over 70 years to be 29.4% (Travers, Byrne, Pachana, Klein, & Gray, 2013). The prevalence of cognitive impairment for medical patients over 70 years in a hospital in Britain was 27% (Whittamore et al., 2014). These high rates of cognitive impairment in hospital have also been linked to negative health outcomes for older patients, such as longer length of stay, functional decline, increased mortality rates, and increases in admissions to long term care (Fong et al., 2012; Marcantonio, Ta, Duthie, & Resnick, 2002; McAvay et al., 2006; McCusker, Cole, Dendukuri, Belzile, & Primeau, 2001; Mukadam & Sampson, 2011; O’Keeffe & Lavan, 1997; Witlox et al., 2010). Cognitive impairments have therefore been established as a particular concern for older people in the hospital.

Within the acute care nursing literature, there is strong emphasis on the role of nurses in affecting the trajectory of older people with cognitive impairments during their admission to hospital for an acute health condition (Flagg, Cox, Mcdowell, Mwose, & Buelow, 2010; Irving, Fick, & Foreman, 2006; Morency, Levkoff, & Dick, 1994). Cognitive conditions can be present when older people are admitted to hospital but can also emerge or change during the course of their admission. Changes in cognition in hospital can be the result of developing physiological conditions such as dehydration or urinary tract infections, or they can be a response to medical interventions such as anesthesia or particular medications (Cole, 2004; Freter & Rockwood, 2004; Saxena & Lawley, 2009). Nursing interventions such as monitoring medications for potential complications, ensuring safety procedures are put in place, decreasing sensory stimuli, and ensuring adequate sleep, nutrition, pain control and mobility are all encouraged in the nursing literature to help prevent cognitive deterioration or limit the negative outcomes

from cognitive conditions (e.g. Boltz, Capezuti, Fulmer, & Zwicker, 2012; Harvath et al., 2006; Hshieh et al., 2015; Moyle, Olorenshaw, Wallis, & Borbasi, 2008).

There is an underlying supposition in the literature related to cognitive impairments in hospitalized older people that it is essential that nurses identify cognitive impairments so appropriate nursing and medical interventions can be initiated. Nursing literature, and health care literature more generally, have focused on identifying cognitive impairments through the use of cognitive assessment tools (Doerflinger, 2007; Greenberg, 2012; Waszynski, 2001) and there are a multitude of such tools available for use by nurses in acute care (Cullen, O'Neill, Evans, Coen, & Lawlor, 2007). Nursing scholars have, over the past 30 years, focused a great deal of attention on the application of assessment tools that can accurately identify cognitive impairments (e.g. Milisen, Braes, & Foreman, 2012; Registered Nurses' Association of Ontario, 2010). I argue that these tools have been developed and promoted for use by nurses, without sufficient consideration of their appropriateness for nurses' practice. There is reason to believe they do not capture the nuanced understanding of cognitive function nurses need in order to proceed with the kind of care that can improve the situation of older patients.

Health care literature about judging cognition in older people is largely based on a particular understanding of judgment: the technical-rational model, whereby problems—such as cognitive impairments—are identified and scientifically validated. Subsequently, practitioners, such as nurses, implement standardized interventions to lead to a controlled outcome (Polkinghorne, 2004; Taylor, 1991). Nursing scholars have criticized this view as inadequate to fully account for the complexity of nursing judgments (Benner, Tanner, & Chesla, 2009; Thompson, 1999). I contend that this accepted view of judgments, which

underlies much of the current nursing scholarship regarding cognition in older hospitalized patients, is problematic, and through approaching the subject from a different perspective, it is possible to make significant contributions to gerontological nursing scholarship.

In an attempt to articulate the complexity of nurses' judgments about the cognitive function of older patients, I have approached this research from a different conceptual perspective to the traditional technical-rational understanding. I suggest that nurses use practical judgments to understand the cognitive function of their older patients. Practical judgments are used to determine good action in particular situations and reflect nurses' understanding of each particular patient, including an understanding of the patient's cognitive function. Practical judgments are based on diverse evidence, which can include traditional scientific knowledge developed through the use of cognitive assessments and weighed along with other evidence. Furthermore, practical judgments are organized through social relations, including relations of power, which are reflective of the context of nursing practice. In Chapter 3, I will further describe these two distinct approaches to understanding nurses' judgment of cognitive function and how nursing scholars have taken up each approach.

Nursing scholarship tends to focus on identification of cognitive *impairments* to the exclusion of more nuanced understandings of cognitive *function*. The phenomenon of cognitive function is more complex than the mere absence or presence of impairment, and concerns the ability of older patients to engage with those around them and to actively contribute to improving their own health. Cognitive function is one element that nurses need to evaluate in a range of evaluations concerning each patient and how they

can function and collaborate with the nurse to ensure they are safe and their physiological status can be maintained. For nurses working with older people in acute care, this complexity is reflected in how they judge patients' cognitive function and, moreover, how they enact nursing care with each particular patient.

Practical judgments concern deliberation about good action, and practical judgments about cognitive function are one implicit and fundamental part of nurses' considerations about how to act and what good action means in particular situations. Nurses' actions in practice reflect a sophisticated understanding of the patient and their particular situation, and their understanding of the individual's cognitive function contributes to how nurses determine their actions. Practical judgments are not neutral and are concerned with actions that will improve the situation of older patients (Moser, 2010).

Determining what actions will bring about improvement in a patient's situation necessitates deliberation about various kinds of evidence regarding multiple, connected aspects of the patient as well as knowledge of their particular situation. Nurses gain evidence for judgments through relationships with patients and family members (Benner et al., 2009; Malone, 2003), interactions with other hospital staff, and through the use of technologies, such as documentation systems.

Practical judgments are further coordinated through social relations in hospital. The place of health care is important to how practitioners understand their role and how they enact their practice (Cheek, 2004; Liaschenko, 1994; Poland, Lehou, Holmes, & Andrews, 2005). Acute care settings are not neutral and reflect relations of power that have come to be embedded in what is considered valid knowledge and what actions are considered appropriate (Cheek, 2004; Liaschenko, 1994). Documentation systems are a

particular example of how embedded relations of power contribute to defining the work of nurses (Poland et al., 2005; Rudge, 2011). An examination of the social relations of acute care can contribute to uncovering knowledge used in practice and to articulating the complexity of nurses' practice.

Research Questions

In order to examine nurses' practical judgments about the cognitive function of their older hospitalized patients, I conducted a focused ethnographic study. The research questions that guided this study are:

1. What evidence do nurses use to judge cognitive function of older people in acute care?
2. How is evidence weighed in deliberations about cognitive function?

This study has approached the subject of judging cognitive function from a perspective that enables an inclusive understanding of evidence, and where weighing of evidence is understood as occurring through deliberation about good action. Approaching the research from this perspective provided the opportunity to uncover hidden knowledge used by nurses, and to examine the values that guide nurses' actions related the cognitive function of older patients in hospital. This approach has provided a foundation from which to examine how judgments are based on various kinds of evidence including those outside the technical-rational model. It has allowed for an examination of how judgments are socially organized and how relations of power play a role in nurses' understanding of the cognitive function of older patients. Furthermore, it ties judgments about cognitive function to the actions nurses take in practice so that actions can be used to learn about how nurses make sense of their patients' cognitive function.

In summary, there are a large number of older people in hospitals, and nurses enact the care of older patients in part based on judgments about their cognitive function. The cognitive function of older people is of particular concern to nurses in acute care as cognitive impairments are common and have significant implications for how care is provided, and ultimately, for the health of older patients. While assessment tools have been developed to support identification of cognitive impairments, approaching the understanding of cognitive function solely through instrumental means does not fully reflect the necessary complexity of nursing practice. Nurses use a process of practical judgment to guide their actions in practice as they care for older people. It is important to examine nurses' practice around understanding cognitive function from this perspective because it reflects the complex, situated nature of their practice.

In the following chapters, I will describe this focused ethnographic study aimed at examining how nurses make practical judgments about the cognitive function of their older patients in acute care. I will begin by outlining the theoretical and empirical groundwork that forms the foundation for the study. Then I will describe the particular methods undertaken to complete the study. The following four chapters present the findings from this study and describe the complex and situated judgments that nurses make about the cognitive function of older patients. After the presentation of the findings, I will discuss them in light of current understandings in nursing scholarship. Finally, in the last chapter I will draw conclusions through recommendations and implications stemming from this study.

Chapter 2: Theoretical Framework

In the following two chapters I will discuss the theoretical and empirical foundations that guided this study. To begin, I will describe the theoretical perspective that allowed an examination of nurses' practical judgments about cognitive function in acute care, including a consideration of various kinds of evidence, the context of acute care, and how judgments are tied to actions in practice. Then I will discuss a selection of nursing and health care literature that supports an examination of practical judgments, and I will argue that the tendency in the nursing literature to examine nurses' understanding of cognitive function from a technical-rational approach is insufficient to capture the complexity of how nurses make judgments about older patients' cognition in hospital.

The theoretical framework for this study has provided a foundation to analyze a broad understanding of judgments about the cognitive function of older patients in acute care. More specifically, I have drawn on an understanding of phronesis to support this wider understanding of judgment. Phronesis is deliberation about good action. This view of judgment recognizes various kinds of evidence and the importance of the particular situation in which judgments are made. Theoretical understandings about how power is enacted in practice were also incorporated into this framework to support an examination of the social organization of practice and how relations of power play a role in nurses' judgments. I further describe these perspectives below, showing how they have been integrated to provide an approach to examining the practical judgments of nurses about the cognitive function of older patients that is the foundation for this study.

Phronesis

The theoretical framework of this research project is influenced by the work of Aristotle, who wrote about virtues. Virtues, according to Aristotle, are the characteristics necessary to live a good life, and can be divided into moral virtues and intellectual virtues. Central to this project are the intellectual virtues, which concern how individuals think and act. Aristotle articulated three types of intellectual virtues: *episteme*, *techne* and *phronesis* (Aristotle, trans. 1999; Edel, 1982). Episteme can be understood as scientific knowledge. It is the understanding of things that are concrete and that have a stable nature; they must be the way they are. Epistemic knowledge comes from what can be observed. For example, understandings about how particular medications work to affect disease progression would be a form of epistemic knowledge in nursing.

The two other intellectual virtues are related to knowledge of action. *Techne*⁴ refers to reasoning about actions related to production; it is related to human activities that bring something into existence that did not exist before (Polkinghorne, 2004; Kemmis, 2012). The action that is determined by *techne* is referred to as *poiesis*, the ends of which are determined ahead of time, so that “the producer does not determine this end but comes to the task with the end already established” (Polkinghorne, 2004, p. 115). Once a routine for completing the desired end is made, it can be applied in the same way to elicit the same result in other situations, and knowledge gained through *techne* can be shared and used by others. From this view, assessment tools can be a demonstration of

⁴ There is some discrepancy in the way Greek philosophers wrote about *techne*. Notably, Aristotle’s conceptualization of *techne* in *Nicomachean Ethics*, where he contrasts it with *phronesis*, has been shown to be inconsistent with how he refers to *techne* in other writing (Nussbaum, 2001; Polkinghorne, 2004). The idea of *techne* as reasoning about production or craft is more common in his writing and the works of other Greek philosophers and is the view of *techne* I have taken here.

techne. The outcome is to decide if a cognitive impairment is present or absent through the use of a predetermined process. The procedure for completing the assessment is always the same regardless of the situation and the results can be shared with others.

Phronesis, the third intellectual virtue and the most relevant to this project, is deliberation about right action (Aristotle, trans. 1999; Polkinghorne, 2004). It has also been called practical judgment, practical wisdom, or prudence. Like techne, phronesis concerns action but differs in that the outcome of the action is not pre-conceived. In phronesis, one must consider what the best outcome will be and act accordingly through what is termed *praxis* or good action (Kemmis, 2012). Deliberation includes consideration about what is right or good given the particular situation, and the action is dependent on the circumstances in which it is made. There are no absolute rules about what is considered right action in all situations.

Prudence... is about things open to deliberation. For we say that deliberating well is the function of the prudent person more than anyone else; but no one deliberates about things that cannot be otherwise, or about things lacking any goal that is a good achievable action. The unqualifiedly good deliberator is the one whose aim accords with rational calculation in pursuit of the best good for a human being that is achievable in action. Nor is prudence about universals only. It must also acquire knowledge of particulars, since it is concerned with action and action is about particulars. (Aristotle, trans. 1999, 1141b 10-17)

Unlike techne, which is based on knowledge of production, phronesis is based on a range of knowledge and reflects a nuanced understanding of the particulars of a situation

(Polkinghorne, 2004). Phronesis is about deliberation on how to act so that the best outcome in a particular situation is manifest.

The notion of phronesis was used to guide this research project, and I will discuss two interrelated aspects of phronesis that are particularly relevant to an examination of how nurses judge cognitive function: the moral nature of deliberations and the importance of the particular situation.

Moral nature of deliberations. Phronesis is deliberation or calculation regarding right action; there is a weighing of possibilities to determine the best action for a particular situation. Phronesis concerns using an understanding of what is right or good to guide actions. Nurses' work is moral in nature and nurses continually act on their moral knowledge (Bishop & Scudder, 1997). Practices have moral components that are reflective of the purpose of the practice.

For nurses, what is considered right and good action depends on the goals or the ends of nursing practice in the context of their work. According to Aristotle, goals guide practitioners in determining best action (Polkinghorne, 2004). There are three characteristics of goals that are important. First, nurses are often working toward multiple goals in practice (MacIntyre, 2013), working toward reaching them simultaneously, or prioritizing their importance. For example, when bathing a patient, a nurse will support a positive experience for the patient along with meeting the criteria for good hygiene. Second, the goals of practice are not necessarily explicit, but develop over time and come to be a shared understanding by those within particular social groups (Cetina, Schatzki, & Von Savigny, 2000). Third, in the acute care environment, the goals of nursing practice are not only determined by what are considered good ends within nursing, but are also

influenced more broadly by the values of society and more specifically by the acute care health care environment.

Importance of the particular situation. According to Aristotle, deliberation about good action is dependent on the particular situation. In his discussion of phronesis, he suggests that deliberation about action takes into account the environment and the particulars of those who are involved. What is considered good in a particular situation is dependent on the values in that setting and judgments are tailored to the situation so that the action taken will reflect those values (Taylor, 1989). Due to the local and situated nature of deliberation in phronesis, there are no firm rules about how to proceed in action. Rather, individuals use their knowledge of the particular situation within the wider context to determine the best course of action.

This is a critical point when considering nursing practice, which exists within a social framework; it is impossible to remove nursing practice from the environment in which it is practiced (Liaschenko & Peter, 2004). Nurses serve a role within society at large and the work they do is influenced by societal values, such as the values around aging in Western society. Moreover, the nature of nursing practice can change with social influence from both inside and outside the health care community (Liaschenko & Peter, 2004). These broad values, however, play out differently depending on the particular situation. Nurses make practical judgments based on particular situations, in a place that is constituted by professional and societal values.

Phronesis, therefore, is a process of deliberation about good action that includes consideration of what is best within a particular situation. Understanding nursing practice as a form of phronesis provides a foundation for understanding how nurses deliberate

about action. From this perspective, nurses working with older people deliberate on how to best proceed with their care. The outcome of the deliberation is embedded in the actions the nurse performs. For example, practical judgments about cognitive function would be seen in how nurses implement safety procedures or review medication records. Deliberation in nursing is also structured by socially constructed ends that are influenced not only by ends inherent in nursing, but by ends that are valued in the hospital context. Nurses' understanding of cognition is not solely the presence or absence of cognitive impairment, nor is it a definitive conclusion that is stable over time and easily passed on to others. Rather, it is the product of continual deliberation about good action that is dependent on the particular situation of the patient at any given moment.

Power

While phronesis provides an important foundation for understanding how nurses judge cognitive function in acute care, it does not take into account the role of power relations in shaping the work of nurses in health care settings. Aristotle's conceptualization of phronesis did not acknowledge how struggles over power and existing power imbalances can influence how judgments are made in practice (Flyvbjerg, 2001). Relations of power influence the organization of health care settings as well as the practice of nurses. I am drawing on the work of Michel Foucault who provided a particular perspective on power and how it plays a role in everyday interactions in practice. By using this notion of power to study social relations and critically examine nurses' practice, it is possible to uncover relations of power that will provide a foundation for questioning assumptions and challenging the status quo.

Following the work of Bent Flyvbjerg (2001), this study integrates Foucauldian notions of power with phronesis to strengthen the foundation for uncovering new knowledge about how nurses judge the cognitive function of older people in hospital. In the following section, I will discuss my understanding of power and argue that it is consistent with Aristotle's notion of phronesis. To begin, I will discuss two important areas of Foucault's work that influence my perspective: the enactment of power and the productive nature of power.

Enacting power. Unlike some theorists who describe power as something that can be possessed, Foucault presents an understanding of power as being enacted (Foucault, 1977/1984). Power is not something possessed by individuals in a privileged social position, nor is it distributed to individuals through institutional or political authority. Rather, power is present in social interactions and plays a role in everyday encounters (Foucault, trans. 1980; 1977/1984). Nurses are able to enact power in their practice, and those with whom they interact also enact power through their actions. An examination of how nurses practice, and more specifically, sources of conflict and struggle, can uncover knowledge about relations of power in acute care settings and their influence on how nurses judge the cognitive function of older people.

Productive nature of power. Foucault argued that relations of power contribute to defining what is considered valid knowledge over time. Rather than being a negative and oppressive force, Foucault describes power as being productive and contributing to the understanding of what is considered true (Foucault, 1977/1984; Foucault, trans. 1980). Assumptions about what is valid knowledge are often hidden, but guide action in nursing practice (Foucault, trans. 1980; Wall, 2008). Power, therefore, underlies how

knowledge is used and what is accepted as true in acute care. An understanding of power as productive enables exploration of knowledge and that which is taken for granted in nursing practice to uncover how relations of power have contributed to validating that knowledge. Using this understanding, knowledge can be deconstructed to uncover how power underpins and influences nurses' judgments about the cognitive function of older people in acute care.

Critics of Foucault's work have suggested that it moves toward relativism and does not provide adequate structure to support claims to knowledge (Cheek & Porter, 1997). Foucault's work has also been criticized by feminist scholars who suggest that his view of power as neutral does not recognize the historical position of particular groups, such as women (Cheek & Porter, 1997; Martin, 1982). Integrating Foucault's work with Aristotle's notion of phronesis addresses these critiques. Phronesis is grounded in action in particular situations, and that includes the history that has led to determining the realities of the situation at a point in time. Grounding inquiry in the social and historical context of local actions provides a means for making knowledge claims (Flyvberg, 2001). I argue that this perspective allows for an examination of judgment that includes recognition of the social position of groups including women, nurses, and older adults that has been constructed over time. Combining phronesis with Foucauldian notions of power supports an examination of the historical context that influences nurses' work with older people.

In summary, Foucault presents an understanding of power as occurring through action and contributing to the production of knowledge. These aspects of Foucault's work support an examination of nursing practice with older people in acute care that addresses

how power is embedded in the knowledge nurses use to judge cognitive function and how particular evidence is constructed as legitimate or illegitimate in judgments about cognitive function. In addition, this understanding provides a foundation from which to examine nursing actions and reveal how power influences nursing care.

Theoretical Perspective on Practical Judgment

To further explain the theoretical foundations of this research, I will discuss the integration of phronesis and power and how they informed this study. Through this discussion, I will demonstrate the compatibility of these two perspectives, including their philosophical assumptions. The resulting perspective on judgment, that of practical judgment, provides the foundation for the examination of nurses' practice judging the cognitive function of older patients in acute care, and has enabled the development of nursing knowledge in this area. The discussion will be structured around three central aspects of practical judgments: nurses' actions in practice, the nature of knowledge, and the situatedness of practice.

Nurses' actions in practice. Using a theoretical perspective informed by phronesis and power meant that nurses' actions in practice have been the focus of the research. Both Aristotle and Foucault approach their work from a position where the actions of people at a local level are important to inquiry and serve as a foundation for knowledge development (Flyvbjerg, 2001). Phronesis is the deliberation about particular situations and how action is determined given the specifics of the situation (Polkinghorne, 2004). Foucault's notions of power are concerned with local actions that reflect historical struggles; he asserts that relations of power are enacted through local interactions (Foucault, 1977/1984, trans. 1980). This study is therefore centred on nursing

practice and the actions of nurses in health care settings. Nurses' understanding of cognition is not necessarily stable, but is instead considered over time and acted upon when necessary based on the best understanding possible given the situation. The outcomes of judgments are integral to understanding the deliberation and to what is considered important evidence in those deliberations. This perspective enabled an examination of how nurses' actions in practice reflected their understandings of their older patients' cognitive function. Drawing on nurses' actions in practice also grounded the study and provided support for knowledge claims.

The nature of knowledge. A theoretical perspective developed from an integration of phronesis and power supports an examination of judgment that includes a broad understanding of evidence. Phronesis concerns deliberation about good action; knowledge of what is good and right in particular situations is important to determining action (Polkinghorne, 2004). Phronesis is also focused on particular circumstances, and knowledge about the particular comes from engaging with the people the action concerns (Polkinghorne, 2004). Furthermore, relations of power underpin assumptions and determine what is considered legitimate knowledge in the context of nursing practice (Liaschenko & Peter, 2004; Wall, 2008). This perspective provided a framework to explore how relations of power have an impact on the knowledge used by nurses in practice and how power is embedded in the work nurses do. This study was therefore focused on examining a wide understanding of knowledge and how it is used in nurses' practical judgments about the cognitive function of older people in acute care.

The situatedness of practice. This theoretical perspective supports an examination of how nurses' practical judgments about the cognitive function of older

people in hospital are organized through social relations. Nurses act as agents within this structure to determine their actions in practice. Phronesis concerns deliberation over right action in the particular situation; the best action depends on the details of the situation (Polkinghorne, 2004). For an examination of nursing practice in acute settings, the context of the health care environment as well as the situation of the patient are both important to how nurses deliberate over their actions in practice. Foucault's work suggests that power underpins the structures that guide practice and through an examination of the structure, we can uncover implicit values (trans. 1980; 1977/1984). Within the health care context, formal and informal structures are in place to guide nurses' work and are imbued with power. This guiding theoretical framework has enabled an exploration of the organization of nurses' practice and how nurses make practical judgments within the structure to determine their actions around the cognitive function of their older patients. This includes an examination of the particulars of each unique case in practice as well as an exploration of how overarching structures define and legitimate nurses' work in those cases.

Summary

The theoretical framework of this study enabled a rich, contextualized exploration of nurses' practical judgments about cognitive function in acute care. This perspective was developed from Aristotle's notion of phronesis which foregrounds deliberation about good action in particular situations, and Foucault's notion of power that delineates how power is enacted and contributes to what is considered valid knowledge over time. These theoretical perspectives were integrated to provide a framework that focuses on an exploration of practical judgments about the cognitive function of older people in acute

care from a perspective that recognizes a broad understanding of knowledge, the situatedness of nurses' practice, and how judgments are inextricably connected to nurses' actions in practice. In the following section, I will further describe the foundations of this study through an examination of the literature related to practical judgments about the cognitive function of older people in nursing practice.

Chapter 3: Review of Selected Literature

This discussion of existing literature will contribute to the framework that underpins the examination of nursing practice around judging the cognitive function of older patients in hospital. In this chapter, I will argue that nurses come to understand the cognitive function of their older patients in hospital through practical judgments and that the traditional views of judgment that dominate the nursing and health care literature are insufficient to account for nurses' complex judgments in their practice.

Practical judgment is deliberation over a variety of types of knowledge that are the foundation for determining how to provide care that will best suit the patient's particular situation. Cognitive function is one implicit and integrated part of the person and nurses' understanding of a patient's cognitive function contributes to nurses' overall understanding about what actions will contribute to improving their situation (Benner et al., 2009; Moser, 2010). This type of judgment is situated within the context of nurses' work and embedded in their actions (Cheek, 2004; Liaschenko, 1994; Malone, 2003). It is important to examine nurses' practice around understanding cognitive function of older people in hospital from a practical judgment perspective because it reflects the complex, situated nature of their practice.

The current scholarship in gerontological nursing, however, is largely focused on applying techniques that adhere to traditional ideals of scientific reasoning to how nurses judge the cognition of older people in hospital. Over the past two centuries the ideals of categorization, control, and problem-solving have come to dominate understandings of the human body (Polkinghorne, 2004; Taylor, 1991) and extend to how scholars, including nursing scholars, tend to understand reasoning in practice (Benner et al., 2009;

Thompson, 1999). This view, what I describe as technical-rationality (Benner et al., 2009; Polkinghorne, 2004), is evident in how health care literature portrays the judgment of older peoples' cognitive function, and it underpins the development and promotion of cognitive assessment tools. Many nursing scholars have also taken up this traditional view of judgment, and it underpins how nursing practice around judgment of the cognitive function of older people in acute care is understood in the nursing literature. However, the technical-rational perspective is insufficient as a foundation for articulating nurses' judgments about the cognitive function of older patients in the context of acute care that will help them enact good care for each particular patient. In order to more fully understand how nurses' practice is reflective of their understanding of older patients' cognitive function, it is necessary to take a different approach to examining their practice. Using an understanding of practical judgment to examine how nurses understand the cognitive function of older people in hospital has allowed me to frame this study and problem in a way that better accounts for the realities of nurses' practice and the situatedness of their interactions with patients. The knowledge gained from this approach will support conclusions that point to novel and potentially improved approaches to nursing care of older people in acute care.

In what follows, I will examine current literature related to how nurses judge the cognitive function of older people in hospital. I will begin by arguing that nurses use practical judgments to come to understandings about cognitive function and will discuss emerging nursing literature to support such a position. Following the description of practical judgments, I will show how they differ from the dominant model of judgments present in the gerontological nursing literature. Through this discussion, I will

demonstrate how the traditional view of judgments is insufficient to fully articulate nurses' practice of understanding the cognitive function of older people in hospital and how attempts to impose such models of judgments on nurses in practice often fail.

Practical Judgments in Nursing Practice

Following critiques of modernity, many nursing scholars have begun to make explicit those aspects of judgment in nursing practice that are different from traditional views of scientific reasoning. These scholars have started to articulate the complex practice of nurses toward making judgments about how to provide the best care for particular individuals. In the following section, I will examine the emerging literature on the nature of nursing practice, how it contributes to the understanding of nursing knowledge used in practice and how nursing knowledge is used to determine action in particular situations in nursing practice. This examination will be guided by how the literature contributes to an understanding of nurses' judgments about the cognitive function of older patients in acute care. Three main themes characterize the nature of practical judgments: 1) practical judgments about the cognitive function of older patients are used to determine how nurses will act in their practice to do what is best for patients; 2) nurses use various kinds of knowledge in practical judgments; and 3) practical judgments are situated in the context of nurses' work.

Practical judgments toward best action. Practical judgments are oriented toward determining best action; they are inextricably connected to what nurses do. Nurses are looking to understand the patient and what their particular circumstances will mean to how they enact care. Nursing practice is fundamentally about action, and judgments in nursing practice are concerned with what actions to take in practice that will

help patients toward a better situation (Bishop & Scudder, 1997; Liaschenko & Peter, 2004; Malone, 2003). Nurses' practical judgments are reflective of their understanding of how to improve patients' health, such as their knowledge of treatment regimes or medications, but also reflect other foundations of nurses' work, such as ensuring adequate nutritional intake, mobility, sleep and hygiene. Practical judgments also include judgments about how nurses manipulate the physical environment and use artifacts to ensure patients are safe and able to function in their particular setting. Each action nurses take requires complex deliberation about what is best in that particular situation.

The words "better" and "best" are not neutral and signify that nurses make determinations about what constitutes good action. Nurses are asked to act in the best interest of patients and they make practical judgments to determine how best to do that (Bishop & Scudder, 1997; Doane, Storch, & Pauly, 2009; Malone, 2003). This is an important element of practical judgments: they are undertaken to determine the best action in particular situations. Proceeding with the best action in practice is dependent on the particular situation and what is right for the circumstances. Nurses are looking to understand the patient, and what their particular situation will mean for how the nurse will enact care. This includes learning about what is right for the person and what is right for those around them, including those caring for them (Moser, 2010). The focus of practical judgments then is deliberation about good action, and is not necessarily aimed at finding the correct solution to an identified problem. As Ingunn Moser suggests, "knowledge is not about facts or truths that are gathered and fixed, but rather a tool or instrument in improving care" (2010, p. 293). Nurses are positioned to determine what is best for patients in particular situations and to act accordingly.

Practical judgments are complex and reflect nurses' prudent consideration of the patients' particular situation in order to determine how best to proceed with care. Through relationships, nurses learn about their patients and come to understand what is good or right for them (Malone, 2003). Practical judgments involve being open to understanding patients' particular positions and how nursing actions can play a role in improving their situation. Moser (2010), while not describing nursing practice specifically, has begun to articulate the complexity of how carers determine how to proceed with care in order to *improve* the situation of older people with dementia. Through her study exploring caring approaches for those with dementia, she demonstrates that practitioners can be effective in improving care by seeking new ways of doing things that fit the particular needs of individuals. Through a reflective approach to interactions with older people, the carers in Moser's study learned what worked well and how to build on the strengths of interactions in subsequent care. The work of improving care was not linear, rather it was directed by examining what worked in interactions with particular people and determining subsequent actions based on those encounters.

Practical judgments about good action are made at a particular moment but reflect deliberation over time. Nurses act in particular instances but they continually construct and reflect on knowledge that contributes to a more nuanced understanding of their patient and the patient's situation that will help them determine the best actions. Nurses have the benefit of spending time with patients and this helps them to understand the particular situation of the patient (Malone, 2003; Moser, 2010). This proximity is important as nurses encounter change and uncertainty in their practice. Nurses reason

about patients over time and are adaptive to change and transitions in patients' status through their practical judgments in particular moments (Benner et al., 2009).

Deliberation in practical judgment is ongoing and reflects continual consideration of emerging information.

The nature of knowledge used in practical judgments. Nurses use various kinds of knowledge in practical judgments. I have already described how practical judgments involve consideration of what is good, and how this necessitates the use of knowledge about what is good or right in particular situations with particular patients. Along with this knowledge, nurses use various other kinds of knowledge to determine their actions. While it is difficult to classify the sophisticated knowledge nurses use in practice, I will begin to describe some of the ways nurses come to appreciate the particular situation of their actions and how that knowledge is used in deliberations about action. Some examples of the knowledge used in practical judgments include: knowledge about what is right for patients (Moser, 2010), knowledge of the hospital culture (Cheek, 2004; Liaschenko, 1994), knowledge of the patient gained through relationship (Malone, 2003, Moser, 2010), scientific knowledge (Benner et al., 2009; Liascheko, 1994), and embodied "know-how" (Benner et al., 2009).

Knowledge of the particular situation includes knowledge gained through relationships and interactions (Cheek, 2004; Benner et al., 2009; Malone, 2003; Moser, 2010). Writing about hospital nursing in the United States, Ruth Malone (2003) draws attention to the importance of relationship in nursing and how relationships with patients enable nurses to gain knowledge of the patient to act in their best interests. She suggests that being close to patients provides a means for nurses to build relationships through

three nested proximities. The first is physical proximity, where nurses are in physical contact with patients. Through physical interactions, nurses are not only able to observe patients' behaviours but can engage with patients to learn what is important to them (Cheek, 2004; Malone, 2003). The second is narrative proximity, a notion based on the work of Patricia Benner, and referring to how nurses learn a patient's "story", their particular circumstances and situation (Benner et al., 2009; Malone, 2003). Through hearing the patient, family members and other nurses talk about the patient, nurses come to appreciate who the patient is outside the health care setting and how they came to their present circumstances (Benner et al., 2009). This narrative gives nurses an understanding from which to determine how best to act in ways that reflect the patient's particular situation. Finally, through moral proximity, nurses learn how to "be for" patients and come to appreciate the moral obligations to act well for particular patients. Malone asserts, "one cannot 'be for' an abstract class of patients in this way; one is called upon to be for *this* patient, at this moment, in all his or her complexity" (2003, p. 2319).

Patricia Benner and colleagues' description of clinical judgment in nursing practice is useful here as well (Benner et al., 2009; Benner, Hooper-Kyriakidis, & Stannard, 2011). While her work has been criticized for ignoring relations of power and centering judgments on "expert" practitioners (Nelson, 2004; Thompson, 1999), it is worth mentioning here because it further supports key elements of practical judgment. Benner's articulation of clinical judgment reflects how expert nurses act in practice and includes five elements: a disposition toward what is good, extensive practical knowledge developed through clinical experience, nurses' emotional involvement with patients, intuition, and the patient's particular narrative (Benner et al., 2009). Benner's conception

reinforces how nurses act for a particular patient's best interest while considering knowledge of the person and the nurse's relationship with them.

While Benner's conceptualization of intuition (Benner et al., 2009) does not necessarily fit with the understanding of practical judgments, the idea that judgments can be embedded in actions and are not always part of a conscious and rational process is important. Practical judgments are not necessarily explicit and are rather enacted through nurses' practice. Moser (2010) also suggests carers' actions are not necessarily dependent on scientific reasoning but are a reflection of their understanding of what it means to act well. This was exemplified through how carers improved care yet were not necessarily able to account for their reasoning in a traditional, scientific sense.

By describing the knowledge nurses use in practice that is outside the traditional scientific understanding of knowledge, I do not mean to suggest that they discount scientific knowledge in practical judgments. Scientific knowledge is valuable to nurses in deliberation about how to act in practice (Benner et al., 2009; Liaschenko, 1994). Several of the nursing scholars who have begun to articulate the complex practice of nurses recognize that scientific knowledge is integral to practical judgments. Liaschenko suggests that nurses' judgments are partly based on their "surveying and probing the body for physiologic and behavioral transgression extending beyond the normal" (1994, p. 23). She thus recognizes that nurses use knowledge that fits into the traditional scientific model of categorization, intervention and evaluation, along with many other kinds of knowledge that come from nurses' understanding of the particular situation. Benner differentiates practical knowledge from theoretical knowledge and suggests theoretical knowledge, or what I refer to as traditional scientific knowledge, is general

knowledge that can be applied, through action, in various degrees to particular situations (Benner et al., 2009). Practical judgments incorporate scientific knowledge with other kinds of knowledge in deliberations to determine best action.

Practical judgments are based on knowledge that reflects nurses' situated understanding of the whole person. Nurses have an understanding of practice situations which encompass interrelated and inseparable aspects of each person and their particular circumstances. Practical judgments reflect an overall sense of the patient (Moser, 2010), with one part of this overall understanding being their cognitive function. Nurses' practical judgments are not compartmentalized into components with the component of cognitive function isolated from other components and considered separately in deliberations about action. Therefore practical judgments related to cognitive function are not considered in isolation from nurses' knowledge of the person.

The situatedness of practical judgments. Nurses' practical judgments are situated in the health care setting in which they work and reflect the social relations of the context. Being situated in a particular context means that nurses are embedded within a network of social relations that contribute to how they see things and through which power is enacted (Cheek, 2004; Liaschenko, 1994). Drawing on work from social geography, Joan Liaschenko uses the word "place" to signify the space in which nursing care is given and the meaning inherent in that space. Poland and colleagues describe place and space as "multidimensional, contestable and as holding different meanings to different social and professional groups. ...place is conceptualized as more than a physical setting, and instead as a set of 'situated' social dynamics" (Poland, Lehoux, Holmes, & Andrews, 2005, p. 172). The place where nurses provide care to patients is

thus more than a physical location; it is imbued with particular meanings that contribute to how practitioners understand and enact their practice.

The social relations connected to places contribute to how the role of nurses is defined and how they see their position in the context of their work. Practitioners' roles in acute care are socially organized and reorganized over time through social relations (Liaschenko, 1994; Poland et al., 2005). Julianne Cheek, in the context of discussing acute care of older people, says, "the place at which care is received thus works to define the very care that is given and that is it possible to give, as well as the subject positions and roles of the individuals who receive and give that care" (Cheek, 2004, pp. 52-53). She therefore highlights how the situatedness of nursing practice not only shapes nurses' roles but also defines the actions that are possible in the particular context. Nurses' roles are defined through relationships with others, documentation systems, formal policies, informal social norms and values, among various other social relations, internal and external to the nursing discipline.

Liaschenko (1994) was one of the first nursing scholars to examine place and space in relation to nursing practice. Drawing on work done with home care and psychiatric nurses in California, she described how space constitutes the social relations that structure nursing practice. Moreover, she shows that place is not neutral, and that hidden relations of power shape nurses' practice.

Places also organize social space and, therefore, social relations and power, practices, resources, and knowledge. Large-scale social structures intersect with personal agency within a given space, thereby lending authority and legitimation to some agents and constraining others (Liaschenko, 1994, p. 19).

This work foregrounds how social structures contribute to how knowledge is understood in practice and how individuals are empowered or constrained to act in specific circumstances. Like Foucault (trans. 1980; 1977/1984), she argues that power underpins what is considered legitimate knowledge and suggests that relations of power also contribute to determining the actions of practitioners in particular places. Cheek (2004) further contends that places have an organizing effect; they contribute to validating particular actions around how care should be given, by whom, when, and so on. These authors suggest there is a complex interplay between actors and social structures, and that places contribute to how actions are considered more or less feasible given how they are understood in practice. Elizabeth Peter (2002) further demonstrates how place “inhibits and enhances” nurses actions in her historical examination of nursing practice in the home. She argues that nurses’ ability to act well is influenced by the place of care. The knowledge, meaning and social structures inherent in places constrain nurses’ actions in particular ways and empower them to act in other ways.

The context of nurses’ work contributes to how they construct knowledge and use it to determine action. Malone (2003), drawing on Liaschenko’s work, has further explained how nursing practice is situated in place. In her discussion of proximity, she highlights that relationships with patients are contingent on interactions that are in turn organized through social relations. She further demonstrates how spatial-structural dynamics, such as social expectations around reporting, accounting, categorization, efficiency measures, and standardization, influence the proximity of nurses to patients in hospital and thus affect relationships between nurses and patients. Such social relations contribute to organizing nurses’ work and how they are able to develop knowledge of

their patients. Practical judgments rely on nurses having a nuanced understanding of patients developed through interactions, and include understandings of the particular situation of the patient as well as knowledge of what is right given their particular circumstances. The context of nurses' work both empowers and constrains nurses to construct particular kinds of knowledge to use in such judgments.

In summary, I have shown what nurse scholars have had to say about three particular aspects of practical judgment in nursing practice. More specifically, I drew from a body of literature that approaches nursing practice differently than traditional scientific reasoning. The scholarship discussed here provides support for a view of nursing judgment that is based on doing what is good in particular situations, based on complex knowledge of the circumstances and situated in the context of practice.

The Place of Acute Care of Older People

As I have argued, the place of care holds particular meanings for different social groups and contributes to practitioners' practical judgment about actions (Cheek, 2004; Liaschenko, 1994; Poland et al., 2005). This is true of the place of acute care and the care of older people within such a place. Because older people have a unique position in society that is reflected in the values of the acute care setting and in nursing practice, they occupy a unique place in acute care (Cheek, 2004).

Older people are not "typical" patients in acute care; by typical I mean the fictional, standard patient to which acute care is generally oriented. Acute care hospitals are understood to be places of cure, meaning that holistic or rehabilitative interventions can be deemed less important in acute care settings (Cheek, 2004; Sellman, 2009). This may affect how nurses care for older patients who have needs that are not considered

curable, such as chronic conditions that complicate care and impede discharge. The acute care environment is further characterized by a focus on technology and providing technical care is prioritized over what is considered basic nursing care, that of providing bodily care to older people (Cheek & Gibson, 2003; Dahlke, Phinney, Hall, Rodney, & Baumbusch, 2014; Daykin & Clarke, 2000)

Cheek has critiqued acute care hospitals as a place where older people come for care to improve their health (Cheek, 2004; Cheek & Gibson, 2003). Drawing from two qualitative studies conducted in Australia that explored nurses and older patients' perspectives of acute care, she notes how often there are conflicts between the needs of older people and the acute care setting (2004). When conflicts arise, it is often the older patients that are seen as the problem, and not the place. The outcome of such conflicts is that acute care settings are not seen as appropriate places for older people despite older people comprising the main population of acute care (Cheek, 2004).

Nurses' perceptions about their care of older people in acute care are socially organized and reflect the values of the place of care (Cheek, 2004; Cheek & Gibson, 2003; Dahlke et al., 2014). Nurses recognize the complexity of care for older people, particularly their assessments and social aspects of care, but find it difficult to account for such complexity in how they provide them care (Cheek & Gibson, 2003). Nurses understand their practice as being constrained by the structure of acute care, such as limited resources, and they characterize their work as a struggle to provide good care (Dahlke et al., 2014).

A team of researchers exploring dignity in health care practice from the United Kingdom has explored the structure of acute care and how it relates to the provision of

care for older people (Calnan et al., 2013). Calnan and colleagues reported on an ethnography of the structure and provision of dignified care of older people in four acute care settings and found that hospital staff considered the acute care setting “not conducive for the care of older people” (2013, p. 472). The authors provide several examples of why this is, including how the restructuring of the British health care system has led to the prioritization of recording, auditing and accountability over other aspects of care provision. Characteristics of the acute setting such as these were found to be detrimental to the care of older people because they encourage practitioners to focus on the “intellectual work” of acute care rather than the important work of relating to older patients. The acute care context is focused on risk aversion, including managing the safety risks of older patients, and contributes to practitioners focusing their efforts on minimizing risk rather than other care work (Calnan et al., 2013; Dahlke et al., 2014). Overall, Calnan and colleagues suggest that the priorities of the system can overtake the needs of older people, so practitioners focus on completing the tasks of the organization rather than providing dignified care to older people. Although from a British perspective of their particular health care system, Calnan and colleagues provide a picture of how health care organizational structuring can play a role in nursing care provision for older people that is relevant to the Canadian context.

The view of older people, and particularly those with cognitive impairments, in society is often characterized by ageism and stigma (Balas, 2011; Herrick, Pearcey, & Ross, 1997). Dahlke and Phinney reported that nurses in acute care spoke of their work with older people as “a nurse’s burden and an obstacle to the more important work of caring for younger adults” (2008, p. 45), showing that the care of older people held little

value to the nurses and led to frustration in their work. Furthermore, conflicts between older people and the acute setting demonstrate that the care of older people is not valued in such environments and that, in acute care settings, the work of practitioners can be unfairly prioritized over the needs of older patients (Calnan et al., 2013; Cheek, 2004). Marianne McCarthy has also shown that values around aging and older people contribute to how nurses judge their cognitive function in acute care (2003a; 2003b). Her foundational study used qualitative methods to develop a grounded theory of nurses' clinical reasoning related to understanding delirium in hospitalized older people but was based on the premise that nurses used "faulty clinical reasoning" (McCarthy, 2003b, p. 90). Despite this limitation, the study did provide some support for the idea that nurses use various reasoning strategies for different situations, and that values play a role in nurses' judgments related to cognition (2003b).

This discussion has examined some of what is known about acute care for older people from a perspective that recognizes the complexity of place, including the meanings that are defined in place and how place contributes to structuring nurses' work. Nurses' roles caring for older people in acute care are socially organized and defined through social relations. The context of nurses' work with older people is defined through social values about aging and the care of older people. While nurses recognize the complexity of caring for older people in acute settings, there is a tendency to prioritize the intellectual tasks associated with the organization over the less valued care of older people.

The Dominance of Technical-Rationality

While nursing scholars have begun to articulate a complex picture of nurses' practice and how they use a variety of knowledge in deliberations about action in practice, these depictions are far from the norm in health care literature. The health care literature, including gerontological nursing literature, tends to account for judgments about action in practice through traditional views of scientific reasoning. In the following section, I will describe what has been called the technical-rational model of reasoning (Polkinghorne, 2004) and demonstrate that it is the dominant approach to knowledge development related to how nurses judge the cognitive function of older people in acute care. Specifically, I will demonstrate how cognitive assessment tools are examples of technical-rational reasoning that dominate the nursing literature on how nurses ought to understand cognitive function in practice. This discussion will be the foundation for critiques that such an approach is incongruent with the complexity of nurses' practical judgments about cognitive function in acute care.

The technical-rational model of reasoning has developed over the past two hundred years to be the dominant view of judgment in Western society (Taylor, 1991; Polkinghorne, 2004). This view is pervasive in health care literature and has had significant implications for health care practice. Moreover, technical-rationality underpins much of the nursing literature related to how nurses judge the cognitive function of older people in hospital. In this next section, I will describe the technical-rational model and how it dominates the literature about nurses' judgment of the cognitive function of older people in hospital.

The technical-rational model of reasoning is underpinned by ideals that came to prominence through modernity (Taylor, 1991). Through modernity, there have been significant advances in science and the use of scientific techniques to assist in imposing control over the natural world (Benner, 2000; Polkinghorne, 2004; Taylor, 1991). Technical-rationality is the underlying reasoning that guides systematic exploration of problems to identify and implement effective solutions (Polkinghorne, 2004). Technical-rationality is characterized by reasoning that follows a series of steps toward ameliorating a problem. First, the problem is identified as a specific example of a problem that has been previously identified and scientifically examined. Then interventions, which have been tested and validated, are implemented to address the problem in order to bring about a predicted outcome. Technical-rationality is a particular kind of problem solving based on the application of scientific knowledge in the form of standardized approaches to attain particular solutions. Technology from this view is a standardized tool that has been developed through scientific testing and is deemed effective for addressing particular problems over a range of situations. Despite various critiques (e.g. Benner, 2000; Patel, Kaufman, & Arocha, 2002; Polkinghorne, 2004; Simmons, 2010; Thompson, 1999), technical-rationality dominates the health care literature.

Cognitive assessment tools. Technical-rationality underpins a large part of health care and nursing scholarship around the understanding of cognitive function in older people. Several cognitive impairments have been scientifically established and identifying these impairments is understood as the foundation for determining nursing actions. Following from identification, the assumption is that scientifically tested and validated interventions can be put in place to treat the condition and minimize the

negative outcomes with which it is associated. The dominance of technical-rationality is expressed through the development and promotion of cognitive assessment tools as best practice for nurses judging cognitive function in hospital. Cognitive assessment tools are technologies for identifying and categorizing cognitive impairments; they are used to help practitioners categorize problems.

Nursing literature about how nurses come to understand the cognitive function of older people is overwhelmingly focused on the use of cognitive assessment tools. Nursing and health care literature promotes such technologies as the best way for nurses to judge cognitive function in many contexts including acute care (e.g. Canadian Coalition for Senior's Mental Health, 2006; Doerflinger, 2007; Greenberg, 2012; Milisen, Braes, & Foreman, 2012; Registered Nurses' Association of Ontario, 2010; Waszynski, 2001). Nurses in acute care have many options for formal tools to assess cognitive function in older adults; Cullen, O'Neill, Evans, Coen, & Lawlor (2007) identified no fewer than 39 psychometric assessment tools that have been scientifically evaluated and shown to be effective, to various degrees, in identifying and monitoring cognitive impairment in older adults.

I will describe three cognitive assessment tools that are common in nursing and health care literature to demonstrate how they align with technical-rational approaches: the Mini Mental State Exam (MMSE), Montreal Cognitive Assessment (MoCA) and Confusion Assessment Method (CAM). These tools are based on observable patient behaviours, and are standardized and systematic; they can be consistently applied across contexts and patient populations.

The MMSE was originally developed in the 1970s and has since been one of the most prominent of the cognitive assessment tools in health care literature. It is a series of 11 questions asked to the patient to determine a score out of 30, which is then compared to a cutoff indicating whether a cognitive impairment exists (Folstein, Folstein, & McHugh, 1975). The MMSE has good psychometric properties and is used to identify dementia and to monitor cognitive impairment over time, but is less reliable in the accurate detection of other kinds of impairments (Folstein, Folstein, & McHugh, 1975; Tombaugh & McIntyre, 1992).

The MoCA was designed more recently to identify Mild Cognitive Impairment (MCI) (Nasreddine et al., 2005) and to some extent, mild cases of dementia. Like the MMSE, the MoCA is a series of 11 questions, and patient responses are evaluated to determine a score out of 30 (Nasreddine et al., 2005). Many of the questions overlap with the MMSE but there are some important differences between the tests that make the MoCA more sensitive to milder forms of impairment (Larner, 2012). The MoCA has been widely evaluated for its effectiveness in identifying impairments and has shown good psychometric properties (Larner, 2012).

The CAM is commonly recommended for identification of delirium. The CAM is an algorithm; information that is gathered through a patient interview and observation is used to determine if the criteria for delirium are present (Inouye, Alessi, Balkin, Siegal, & Horwitz, 1990). One key feature of the CAM is that it requires knowledge of whether the person's cognitive function has undergone a recent change from their baseline (Inouye et al., 1990). This information can be gathered from family members or other health care professionals. The CAM has good psychometric properties (Inouye et al., 1990) and a

high rate of use in research and in clinical interventions (Wei, Fearing, Sternberg, & Inouye, 2008).

The orientation assessment. The MMSE, MoCA and CAM are examples of cognitive assessments that are widely accepted in the health care and nursing literature as methods to identify particular cognitive impairments. They are based on observable patient responses and are systematic and standardized. I will briefly describe a fourth technology for assessing cognitive function, the orientation assessment, which adheres to the values of the technical-rational approach. Cognition has been divided into several domains, and the orientation assessment is used to assess one of those domains: orientation. It is a relatively short assessment tool in comparison to the MMSE, MoCA or CAM and consists of four questions that indicate the person's level of orientation to four aspects of their situation: who they are, where they are, what the date is and their current circumstances. This tool has been largely discounted in the literature as it has been found to be an ineffective method to identify cognitive impairments (Mezey, Fulmer, & Abraham, 2003; Palmateer & McCartney, 1985; Souder & O'Sullivan, 2000). Yet it is important to this discussion because it has been shown to be widely used among nurses in practice (Schuurmans, Duursma, Shortridge-Baggett, 2001; Souder & O'Sullivan, 2000; Steis, Penrod, Adkins, & Hupcey, 2009). In fact, some nursing literature suggests that the tool most commonly used by nurses to assess cognition is the orientation assessment (Schuurmans et al., 2001; Steis, 2009).

There are many more technologies available to nurses in acute care to identify cognitive impairments. The Geriatric Depression Scale (GDS) is widely recommended for the identification of depression that may be a cause of cognitive symptoms

(Greenberg, 2012). The Mini-Cog is a tool that can be used by nurses to assess executive function (Doerflinger, 2007). The NEECHAM scale (named for its developers, Neelon and Champagne) was developed specifically for use by nurses at the bedside and is also recommended for identifying acute confusion in hospitalized patients (Neelon, Champagne, Carlson, & Funk, 1996).

Cognitive impairments. The purpose of cognitive assessment tools is to identify cognitive impairments. In the technical-rational model, categorization of a problem is necessary in order to determine the actions that can best address the problem. Three particular conditions with cognitive symptoms dominate nursing literature and are often referred to as the 3Ds: dementia, delirium and depression. One further condition has been increasingly seen in health care literature in the past decade: Mild Cognitive Impairment or MCI. I will briefly describe how these four conditions are understood in order to provide a foundation for further discussion.

Delirium is understood to be the most common adverse condition for older people in hospital (Inouye, Schlesinger, & Lydon, 1999). Often referred to as acute confusion, it is also the most common cognitive impairment discussed in acute care literature. It has a sudden onset and is characterized by inattention, impairments in reasoning, and disordered thoughts (American Psychiatric Association, 2013). Delirium is unique because symptoms fluctuate over a short period of time and the condition is often reversible so that patients return to normal functioning over the course of hours or days (Cole, 2004; Freter & Rockwood, 2004; Saxena & Lawley, 2009). Three subtypes of delirium have been identified: hyperactive, hypoactive and mixed (Saxena & Lawley, 2009; Stagno et al., 2004). Hyperactive presentation is associated with hyper-vigilance,

hypersensitivity to stimulus, and being easily startled, whereas hypoactive presentation is associated with drowsiness and lethargy (Stagno, Gibson, & Breitbart, 2004).

Like delirium, dementia is a common condition in older people. Dementia, or neurocognitive disorder, is a degenerative condition that may include changes in memory, language, perception and executive functioning leading to significant impacts on social or functional ability (American Psychiatric Association, 2013). There are several types of dementia, and each form has different pathophysiology, and often, differences in presentation. The most common type is Alzheimer's disease, which accounts for about 63% of dementia cases in Canada (Alzheimer's Society of Canada, 2010). Other types include vascular dementia, Lewy body dementia and frontotemporal dementia. Dementia is also attributable to progressive and degenerative conditions such as Huntington's disease, Parkinson's disease, HIV and Creutzfeldt-Jakob disease. Individuals often have more than one type of dementia (Alzheimer's Society of Canada, 2010).

Depression is a significant concern for older people and has implications for their cognitive function. Depression is a condition of decreased mood that is accompanied by low self-esteem, feelings of hopelessness and helplessness, and decreased pleasure in activities that were once enjoyable (American Psychiatric Association, 2013). Depression often has cognitive symptoms in the older population including cognitive disturbances, delusions, poor concentration, slowed thinking, and memory impairment (Cole, 2004).

MCI is characterized by mild memory impairment and changes in other cognitive processing that do not interfere with daily functioning (Dixon et al., 2007; Petersen et al., 1999). Also called cognitive impairment no dementia, age-associated cognitive decline,

preclinical Alzheimer's, and other names, the categorization MCI is most common in current literature. There is evidence that MCI is an indicator of future decline in cognition, and it is thought that early recognition of MCI may provide an opportunity to implement strategies that can effectively prevent further decline (Dixon et al., 2007; Lonie, Tierney, & Ebmeier, 2009; Petersen, 2004; Petersen et al., 1999).

In summary, the use of cognitive assessment tools to identify cognitive impairments is promoted in the nursing and health care literature as the best way for nurses to understand the cognitive function of older people. Much effort has been invested in developing tools that can accurately identify specific impairments such as dementia, delirium, depression and MCI.

Incongruence of Technical-Rational Dominance and Nursing Practice

There is a body of literature that suggests that nurses do not do a good job of identifying cognitive impairments in the hospital (e.g. Gustafson, Brännström, Norberg, Bucht, & Winblad, 1991; Inouye, Foreman, Mion, Katz, & Cooney, 2001; Rice et al., 2011; Steis & Fick, 2008). For example, Steis and Fick (2008) conducted a review to summarize the health care literature reporting nurses' recognition rates of delirium. They found ten articles, published between 1991 and 2007, which noted rates of recognition between 26% and 83%. Indeed, throughout the literature, nurses are blamed for not recognizing or identifying cognitive impairments and there have been suggestions that such "under-recognition" may be putting older patients at risk of negative outcomes. I argue that this literature unfairly characterizes nurses as incompetent or undereducated and that the "failure" of nurses to categorize cognitive impairments noted in the literature may be better understood as an incongruence between the technical-rational approach and

the structure of nurses' practice. Interpreting the literature on under-recognition in this way supports a further examination of nursing practice so that the realities of their practice around judging the cognitive function of older patients can be uncovered. The understanding that is developed from such an examination can then be used to present a more nuanced picture of nursing practice around understanding cognition in older people and counter such unfair characterizations of nursing.

Implementation of technology. Cognitive assessment tools have been imposed on nurses without accounting for the suitability of such tools in their practice. Indeed, there is evidence in the health care literature that the implementation of such tools does not always fit well with the nature of nursing practice in acute care. While there is an assumption that nurses have close proximity to patients so are in an ideal position to make judgments about their cognitive function (Rice et al., 2011; Williams, 1991), that is not always the case (Malone, 2003). The tools require resources, such as dedicated time to complete, and nurses may not have access to such resources (Dahlke & Phinney, 2008). Some scholars who have written about the under-recognition of delirium by nurses have suggested that organizational factors may play a role in the use of cognitive assessment tools and recognition rates, but have neglected to further examine these issues (Gaudreau, Gagnon, Harel, Tremblay, & Roy, 2005; Inouye et al., 2001; Rapp et al., 2000; Williams, 1991).

Furthermore, it is possible that nurses' understandings of their patients and their particular situations deter nurses from conducting cognitive assessments (Gemert van & Schuurmans, 2007). Waszynski and Petrovic (2008) reported that nurses were concerned that their patients would be burdened by answering questions for some assessment tools,

such as counting backwards or spelling backwards. Others suggest that some aspects of patients' experience in hospital may be considered more important than completing cognitive assessments. Treloar and Macdonald (1995) speculated on why nurses failed to conduct full cognitive assessments on older patients during the night shift by suggesting the nurses were reluctant to disturb their patients as they slept. Reluctance to conduct a cognitive assessment can be attributed to nurses' complex understanding of the particular situation of their patients and what they have determined to be best action in such situations. Considerations about how the older patient and their experience in hospital contributes to how nurses implement cognitive assessment tools remain largely unexplored in nursing and health care literature. However, the findings from these studies suggest that nurses' understanding of a patient's situation plays a role in how technology is implemented in practice.

Categorization. Categorization of cognitive impairments through the use of cognitive assessment tools can also be problematic for nurses in acute care practice and may contribute to what has been described as under-recognition. The type of information needed for identification and differentiation between conditions are at odds with the structure of nurses' practice. Although categorization of impairments through the use of cognitive assessments is aimed at simplifying and standardizing the task of identifying cognitive impairments, the literature also highlights some challenges for putting individuals into particular categories. The nature of nurses' practice often makes it impossible to distinguish between such conditions.

Ambiguity remains about how cognitive conditions are differentiated from each other and this ambiguity contributes to challenges for nurses to identify particular

conditions in their practice. The nature of cognition and of the cognitive impairments that are commonly described in health care literature often mean it is difficult to uniquely categorize a person's cognition. There are similar cognitive symptoms for many psychiatric disorders including dementia, delirium and depression (American Psychiatric Association, 2013; Meagher et al., 2010; Schuurmans et al., 2001; Waszynski & Petrovic, 2008) and individuals can experience more than one of these conditions at a time. Furthermore, there is often overlap with individuals experiencing, for example, delirium with dementia (Fick, Agostini, & Inouye, 2002; Fick & Mion, 2008) or depression with delirium (Givens, Jones, & Inouye, 2009). The similarity in presentation and potential overlap of conditions means that it is often difficult to distinguish between conditions and to determine how to categorize the cognition of a particular person. The fluctuating nature of delirium also poses challenges to categorization. Delirium symptoms may change between subtypes within a short period or may appear or disappear altogether (American Psychiatric Association, 2013; Cole, 2004; Freter & Rockwood, 2004).

Often the key to differentiating between dementia and delirium is understanding the patients' baseline function (American Psychiatric Association, 2013; Cole, 2004; Freter & Rockwood, 2004); however, the structure of nurses' work in hospital means that they may not have access to such information. The hallmark symptom of delirium is an acute change in cognition from their previous function, and often nurses cannot determine what patients were like before admission to hospital based on the resources they have at their disposal (Irving et al., 2006). There may be limited notes in patient medical records about previous cognitive status, and family members may be the only other source of information about baseline function before admission (Waszynski &

Petrovic, 2008). Obtaining the necessary information about patients' baseline from family members is dependent on nurses being able to interact with them. The nature of nurses' practice in acute care can make it difficult to differentiate between dementia and delirium, as they may not have knowledge of important criteria for accurate differentiation.

Action in practice. The nursing literature around identification of cognitive impairments is based on the assumption that nurses consciously gather particular kinds of evidence toward a conclusion to which they apply conceptual labels such as dementia, or delirium (Steis et al., 2009). Furthermore, the assumption underlying the promotion of cognitive assessment tools for use by nurses in hospital is that once cognitive impairments are identified, standardized procedures with rigorous scientific backing can be implemented to ameliorate the impairment. I suggest that such assumptions should not be taken for granted and argue that actions to improve the care of older people in hospital are not contingent on nurses identifying cognitive impairments. There is literature that suggests nurses, rather than identifying particular cognitive impairments according to the dominant discourse, have another way of understanding cognitive function whereby they implicitly recognize their patients' needs, and through addressing them are inherently addressing the underlying cognitive condition.

There is some evidence that, while nurses may not formally recognize delirium, they do recognize particular symptoms of cognitive change (Laurila, Pitkala, Strandberg, & Tilvis, 2004; Schuurmans et al., 2001). In a study conducted in Finland exploring delirium recognition in hospital, nurses were shown to record symptoms of delirium more readily than physicians diagnosed it (Laurila et al., 2004). Steis and Fick (2008) note that

nurses may not explicitly identify delirium in their patients, but they do recognize when they are in distress, confused or behaving inappropriately, and that they need help. These authors also note that although the term “delirium” rarely appears in nursing documentation, nurses are more apt to describe symptoms such as disorientation, behaviour changes, inattention, or change in consciousness (Steis & Fick, 2008). These findings are particularly important for this study because they support the contention that nurses who are thought to be under-recognizing delirium are indeed contemplating their patients’ cognitive function. What remains to be examined is how nurses’ actions reflect this more nuanced understanding of patients’ cognitive function.

Although nurses may not always report the cognitive function of their older patients, they do recognize when their patients are having cognitive symptoms and when they are in distress. Watching and attending to patients differs from purposefully seeking out particular information in order to apply a conceptual label to a particular component of the person. Liaschenko differentiates observation from surveillance: “Observation is to watch, to attend to, to guard, surveillance is to watch with the aim of direction or control” (1994, p. 20). Nurses’ understanding of cognitive function reflects their understanding of the person’s overall health, function and safety, rather than scientific criteria used for categorization. By limiting the understanding of nurses’ actions to those that reflect a particular diagnosis of a cognitive condition, nurses have not yet been able to make explicit the actions of nurses that reflect their overall understanding of a person’s cognitive function.

Characterizing nurses as under-recognizing cognitive impairments foregrounds the dominance of the technical-rational model of decision making and neglects to account

for how nurses actually perceive and address patients' need for care to improve their situation. Furthermore, this literature constructs nurses as incompetent while not recognizing the complex understandings they use to enact their practice. In order to articulate how nurses judge cognitive function as a foundation for their action in practice, it is important to examine their complex and situated practice rather than oversimplify or isolate the judgment of cognitive function.

Technology and Practical Judgments

Technical-rationality has been useful in many ways but it has limitations. In identifying the limits of such a model for explaining how nurses understand the cognitive function of older patients in hospital, I do not mean to suggest that this type of reasoning has no use in nurses' practice. Indeed, there have been important advancements in understanding cognitive function based on this model, and there is a place for technology in nurses' practice. However, my argument is that the technical-rational model is insufficient to fully understand how nurses come to understand the cognitive function of older people in hospital to determine their action in practice and, furthermore, that an examination of practice from an alternative view of judgment can provide a means for uncovering hidden knowledge nurses use in their practice and for identifying better ways of approaching the care of older people in hospital.

Summary

In summary, I have discussed the literature that supports an examination of practical judgments about the cognitive function of older patients in acute care. Such a perspective on judgment draws attention to how they are related to actions, use multiple sources of evidence and are situated in acute care nursing practice, and will provide a

foundation for advances in gerontological nurses scholarship. This approach differs from traditional understandings of judging cognitive function, which have been shown to be ill-suited as a reflection of nurses' practice in acute care settings. This framework will serve as the foundation for the forthcoming discussion of this focused ethnographic research.

Chapter 4: Methods

I have argued that the current understandings of how nurses make judgments about the cognitive function of older patients in hospital are insufficient to capture the complexity of their practice. To address this problem, I conducted a focused ethnographic study, which included interviews, observation and document analysis on two acute care units in a large hospital. In this chapter, I will describe the research design and demonstrate how it was informed by the theoretical and empirical framework outlined in Chapter 2 and Chapter 3. I will first discuss the tradition of ethnography and provide a rationale for selecting focused ethnography for this project. Then I will discuss the philosophical underpinnings that framed the research process. After giving an overview of the research process, I will describe the methods in detail.

Purpose and Research Questions

The overall purpose of this study was to better understand how nurses judge the cognitive function of older people in acute care. The word “judge” in this context refers to how nurses construct evidence and deliberate to determine their actions in practice. Judging is understood from a perspective that recognizes multiple kinds of evidence, the particular situation of the patient and the context of acute care in influencing nurses’ judgments. These assumptions guided the development of two specific research questions:

1. What evidence do nurses use to judge the cognitive function of older people in acute care?
2. How is evidence weighed in deliberations about cognitive function?

Focused Ethnography

Ethnography was originally developed by naturalists in the field of anthropology who challenged the accepted view that the best way to understand a phenomenon was to control all possible variables and conduct research in laboratories (Hammersley & Atkinson, 2007; Munhall, 2001). Naturalists claimed that it was essential to study social phenomena in a natural environment so that contextual factors could be taken into account (Hammersley & Atkinson, 2007). Ethnography has since been adapted for use in other research traditions and nursing has been quick to appropriate ethnography to build knowledge about how nurses support health in their patients (Streubert & Carpenter, 2010).

For this study, which addresses gaps in the understanding of nursing practice in acute care environments, ethnography is an appropriate choice. It provides a framework to explore the context or place of nurses' work (Streubert & Carpenter, 2010). Moreover, ethnography enables an exploration of how individuals act and use cultural artifacts (such as documents) in their everyday work. Furthermore, this approach supported an exploration of the embodied or tacit knowledge that nurses use in practice, as well as the social organization of nurses' work. In this study, ethnographic methods were used to study practical judgments about cognitive function in nursing practice.

Specifically, I adopted an approach that has been called *focused ethnography*, which is derived from classic ethnographic approaches but is focused on one area of the researcher's own culture (Higginbottom, Pillay, & Boadu, 2013; Knoblauch, 2005; Munhall, 2001; Streubert & Carpenter, 2010). This approach includes shorter time in the field and intensive data collection that is specific to one area of the culture (Higginbottom

et al., 2013; Knoblauch, 2005). For this study, examining nursing practice around understanding cognitive function in acute care settings, a focused ethnography was ideal.

Theoretical grounding of this focused ethnography. Below I will describe three epistemological claims that guided the development of this research project, showing how they are compatible with both the conceptual framework and selected methods. First, it is possible to learn about nursing practice related to judging cognitive function through an examination of nurses' accounts of their practice. Nurses' descriptions of how they make judgments in particular situations, constructed through dialogue, can be used to uncover the knowledge they use in practice. Furthermore, the theoretical perspective that guided the study draws attention to how relations of power structure what is considered valid knowledge (Foucault, trans. 1980). Examining nurses' accounts of their practice and the knowledge they use to make judgments can help make explicit the underlying relations of power. Therefore, interviews were used to examine the understanding nurses have of how they judge cognition.

Second, it is possible to learn about nursing practice related to judging cognition through an examination of actions. Actions can be examined to uncover how relations of power and practical judgments led to the action. The theoretical underpinnings of this study tie nursing knowledge inextricably to actions in practice. I argue that some knowledge used in practice is difficult to articulate without losing the complexity that enables action. This has been described as tacit knowledge: a type of knowledge that enables complex action but which cannot be easily broken into specific steps (Polanyi, 1958; 1967). Knowledge used in action is socially organized through traditions, culture and other social phenomena (Bourdieu, 1977; Polkinghorne, 2004). Examining actions

and acknowledging the complexities of action make it possible to explore the knowledge used in practice. Therefore, observations of nurses' actions in practice were integral to data collection for this study.

Finally, it is possible to learn about nursing practice about judging cognitive function through an examination of cultural artifacts. Cultural artifacts include physical and digital "tools" used by individuals within a given environment, such as documents, equipment, and policies. Cultural artifacts are the result of situated cultural processes that give them purpose (Smith, 2005). Examining artifacts can reveal the knowledge used in their development. Written documents are cultural artifacts that are common in health care settings and represent embedded understandings that can be used to better understand how nursing practice is organized through their use. Documents are not only used by practitioners, but contribute to how practices are enacted (Berg, 1999; Sandelowski, 1988). An analysis of the documents nurses used in their practice, such as those used to assess and record cognitive function, helped inform the findings.

Research Aim and Objectives

The research was conducted with the aim of constructing a text that translates the practice of nurses judging the cognitive function of older patients into language that is accessible to others. The final product is one interpretation amongst multiple possible interpretations of how nurses make practical judgments about the cognitive function of older people in acute care. This interpretation is supported by theoretical and practical evidence. The practical evidence includes data collected from interviews, observation and documents, and interpretations of this data were held against other accounts of nursing practice from the literature. Ultimately, I do not claim that this is a definitive account.

Rather, it is an interpretation that is data-based and theoretically grounded which will contribute to developing further knowledge in gerontological nursing.

Through this focused ethnographic study examining how nurses come to understand the cognitive function of their older patients in acute care, I sought to address five specific research objectives. These objectives served as a framework for how I would answer the research questions.

1. To describe how nurses understand how they judge the cognitive function of older people
2. To gather multiple perspectives about how evidence is used to judge cognitive function
3. To describe how nurses understand cognitive assessment tools in their practice
4. To describe the organization of nursing practice related to the cognitive function of older people
5. To examine how relations of power influence the ways in which evidence is weighted in judging cognitive function

Overview of Research Process

Through this research I sought an understanding of how nurses judge cognitive function of older people in acute care, and in order to develop this understanding, I examined the practice of nurses working in a large urban hospital. Several types of data collection were used to inform the final product of this research including interviews, observation, and document analysis. Two stages of data collection will be described, and although they ultimately overlapped, the two stages served to guide the research process.

To address objectives 1, 2, and 3 related to describing nurses' understandings of their practice, I focused the first stage of data collection on gathering descriptions of particular cases in practice. Flyvbjerg advocates focusing on practice and exploring "the little things" in research (2001). This initial stage of data collection was conducted in one unit of the hospital. I engaged with nurses to observe their work and talk with them about specific interactions that occurred. Through a process of examining cases, I went back and forth between what I observed and what nurses described as the meaning of particular events to come to a better understanding of their practice. By observing and interviewing several nurses, I gathered multiple perspectives about how they understood their practice related to judging the cognitive function of their older patients.

The second stage of data collection addressed research objectives 4 and 5, which were related to the organization of, and relations of power within, nurses' practice. Informed by the first stage, I sought to explore contextual influences on nurses' practice related to judging cognitive function. I continued observing and interviewing nurses and incorporated a second study site on a different unit and document analysis in the research. This stage focused on exploring the social interactions that took place between nurses, interactions between social groupings of professionals, and interactions between nurses and older patients. Another unit was included in the study to provide points of comparison to better understand the hospital context. In order to better understand relations of power, I explored tensions and conflicts in nursing practice related to the care of older people. This stage also incorporated an examination of the documentation systems common in the practice setting. I will expand on further details of the research process in the following sections.

Research Setting

I chose to focus the study around general duty nurses' work on units where nurses generally do not have specialized training and often work with older people who have been admitted to the hospital. This was in part due to my experiences working as a nurse in such areas, and in part due to a dearth of literature examining nurses' care of older people in such areas. Furthermore, I included two units that had different philosophical approaches to providing care, and more specifically, I included a unit with an explicit focus on the care of older people in order to explore differences in the practice of nurses on such a unit as compared to those who work on a unit with adults of all ages.

The first stage of data collection took place on a surgical unit that provided care for pre- and post-operative adult patients who required the services of particular medical specialists. I stayed on this unit for 7 months until I developed a foundational understanding of practice and had gathered multiple perspectives on nursing practice with older people that provided rich examples to begin addressing the first three objectives.

The second stage of data collection expanded the study to a second unit that was solely focused on the acute care of older people. There were philosophical differences in the approach to care for this geriatric unit and the surgical unit, however when I began this study, it was unclear how these philosophical differences would play a role in nurses' practice. Data collection at this stage focused on understanding how the organization of the hospital and nursing units were reflected in the care provided to older people. Specifically, I focused on how older people were viewed in the hospital, how power was enacted, and the differences between practice on the two units. I describe the two units in further detail in Chapter 5.

The units studied were selected based on several inclusion criteria: the nurses were accepting and welcoming of a researcher to their unit, there was relative ease with gaining entry to the site (e.g. I made contact with a nurse leader to facilitate access), and there were commonly older people on the unit.

Gaining access. The process of gaining access to the site was both formal and informal. Formally, I had to get approval for access through the hospital administration as well as the research ethics boards of both the university and the health care facility. Informally, I sought approval from different levels of leadership on each unit including the Patient Services Managers and other practice leaders such as the Patient Care Coordinators and nurse educators.

It was important to build and maintain positive and open relationships with various contacts in the field (Hammersley & Atkinson, 2007; Streubert & Carpenter, 2010). To do this, I allowed several weeks to build trust on the units before starting data collection. This time was spent meeting nurses and others who worked on the unit, explaining why I was there and the purpose of my research. I attended staff meetings and discussed my research with those in attendance. During this time and throughout my time in the field, I endeavoured to provide as much information as possible about my research. I found that sharing information made informants more comfortable with me, and the research process. Particularly after explaining what participation in the research would entail and what I wanted to learn through the research, I found nurses asked more questions about the process and several volunteered to participate.

I had prepared to meet “gate-keepers” in the field, those who could support or hinder access to the site (Hammersley & Atkinson, 2007; Mulhall, 2003). Indeed, I came

in contact with several individuals who facilitated or limited access to the site. In these circumstances, explaining my research in terms that were meaningful to these individuals was important. For example, when talking with managers, it was important to describe how my work would impact nurses' ability to perform their work. There were also people who were not supportive of the research, and in these cases it was important that I was prepared to find alternative methods of access. For example, a practice leader I had been encouraged to seek out for support finding participants did not want to get involved, but I was able to find other practice leaders who were willing to support the recruitment.

Sample and Sampling

I used purposive sampling to select a diverse sample of full-time and part-time nurses and to collect data which captured a broad range of experiences in the hospital. For example, I sought to include nurses who had been working at the hospital for several years, as well as nurses who had very little experience at the hospital. Including nurses with various backgrounds provided opportunities to explore the experiences of these subgroups (e.g. regular or casual staff, those with experience in other work settings, and those who spoke English as a second language). Determining who comprised the study sample was an evolving process as the data collection and analysis processes informed what direction sampling took. Decisions about sampling were based on the emerging interpretations of data and served to identify informants who could provide new perspectives (Higginbottom et al., 2013; Knoblauch, 2005; Streubert & Carpenter, 2010). For example, as I came to learn that nurses sought out colleagues to be translators for patients who did not speak English, I sought to talk with nurses who had experienced being translators for their colleagues.

Registered Nurses (RNs) were the main source of data about nursing practice, although I also sought the perspective of Licensed Practical Nurses (LPNs). While RNs and LPNs have different scopes of practice, in the acute care setting, they are both responsible for assessing and reporting cognitive function.

As I sought an understanding of nursing practice around how nurses judged the cognitive function of older patients, I spoke to many people in the field outside of nursing. While nurses provided insight about nursing practice directly from their experience, those outside of nursing provided contextual and supportive information so I could better understand the culture of acute care for older people. Other participants who contributed to my understanding of the acute care environment included patients, family members, Patient Care Aides (PCAs), physicians and social workers. In various capacities, these individuals helped me to better understand how nurses judged the cognitive function of older patients in acute care. Patients and their family members were particularly important to how I understood nurses' practical judgments about cognitive function and a significant part of data collection included observing nurses interacting with patients and their family. When I had consent from patients and family members, I included their actions and responses in field notes. However, because I was focusing on nurses' practice and their perceptions of their practical judgments about cognitive function, the voices of patients and their family are less frequent in the findings.

Sample. The sample consisted of 21 nurse informants who participated through an observation session, interview or both. They ranged in age from 25 to 58 years (average=37 years). Most of the nurses were women; only four of the informants were men. Nineteen of the informants were RNs, and two were LPNs. The nurses ranged in

experience level as well, from less than one year to 23 years of experience. The majority of the nurses I spoke to were full-time employees; only two were part time. Three of the nurses were float nurses, meaning they worked full-time at the hospital, but were called to work on different units depending on where extra nurses were needed at the time.

This sample size is similar to other nursing studies using a focused ethnographic design (Higginbottom, Pillay, & Boadu, 2013). It allowed me to gather rich data on a variety of situations that were used to examine the phenomena of interest in detail while remaining manageable for a doctoral dissertation (Higginbottom et al., 2013; Sandelowski, 1995).

Recruitment. As a researcher, I proceeded carefully in seeking informants in order to recognize individuals who did not want to participate, but also to give individuals an opportunity to participate if they desired. I also sought to present my research honestly and humbly to the nurses, without arrogance or pretension.

Recruitment of informants was done gradually as I made contact with various formal and informal leaders and developed relationships with staff. After I received approval from the hospital and the front line Patient Services Managers, I began going to the units to speak informally with nurses. With the help of the Patient Services Managers and nursing leaders (Patient Care Coordinators or nurse educators) I put up posters where nurses might see them (a sample poster can be found attached as Appendix A). I introduced myself to staff members, told them about my study, and provided my contact information. While I suggested that individuals call or email me to let me know they were interested in participating in the study, generally informants volunteered during informal discussions on the unit. The observation sessions with nurses gave me more opportunity

to talk with other staff about my research, and proved to be a way for me to demonstrate what would be expected of them if they did participate. I asked informants to tell others about the research and their experiences participating in the study. Some nurses recommended I talk to specific people who they knew would be interested in my study. When I wanted to talk with particular nurses, I asked people with whom I had already developed a relationship to approach them. When individuals said they did not want to participate, I looked for others who could provide a similar perspective to the one I was seeking.

Collecting Data

Viewed from the theoretical perspective guiding this study, data are not something that can be “picked up” or gathered in an objective way; rather, the researcher and informants construct data. Data for this study were collected through buddy shifts, interviews and document analysis. *Buddy shifts* were periods where as the researcher, I partnered with a nurse to observe practice and ask questions about his or her perceptions. Semi-structured interviews were conducted outside of work hours, and were a dedicated time to discuss how nurses understood their practice as well as particular events that occurred during buddy shifts. Documents that were used by nurses on the units were collected and reviewed, and then used to inform further data collection during buddy shifts or interviews. The data related to the documents were the content and structure of the documents themselves as well as notes about how I observed their use in practice and how nurses described their use. A summary of the informants who participated in buddy shifts and interviews on each unit can be found in Table 1.

	1 South - Surgical		2 North – Geriatric	
	Interview	Buddy shift	Interview	Buddy shift
Registered Nurses	8	14	5	5
Licensed Practical Nurses	2	2	0	0
Total	10	16	5	5

Table 1: Summary of informants' participation in data collection on each unit

With this type of study, there are no strict rules about when the data collection process is complete. Therefore I had to structure time in the field and be reflexive about the research process in order to be confident that I had enough good data from multiple perspectives. This was done through careful planning of the research process, constant evaluation of how the research objectives were being addressed, and flexibility in response to experiences in the field. For this study, the data collection process extended from April 2012 to April 2013.

Buddy shifts. A major component of data collection was observing nurses in practice with older patients. To do this I arranged buddy shifts with nurses where I followed them as they interacted with patients, family members and others in the health care team. The buddy shifts were arranged for various times of the day and week, including evenings and weekends, to gather information about different aspects of nurses' practice. The buddy shifts were 3-5 hours in duration so that I could collect data without being overwhelmed. A total of 68 hours of observation through buddy shifts was completed. An additional 40 hours of observation was completed where I was not paired with a specific nurse but spent time interacting with nurses and observing the workings of the units (for a total of 108 hours of observation).

The purpose of buddy shifts was twofold: to observe nurses working in the context of the hospital and to elicit nurses' perspectives about their practice as it was occurring. I observed how nurses gathered evidence about the cognitive function of their patients as well as how they weighed the evidence. I also noted interactions with patients, family members, and other staff members as well as the tasks nurses performed on their own (e.g. charting, medication preparation, safety precautions). I paid particular attention to how nurses engaged with artifacts such as documents and equipment.

I began by using an observation guide (included as Appendix B) but over time, I further refined the focus of observation to better reflect emerging gaps in the data (Mulhall, 2003). This meant that I inevitably had to make choices about what to record and what to leave out during observation. Initially, these decisions were difficult as I worried about missing important data. Over time, as I worked through preliminary data analysis, the decisions became easier and field notes were often directed to particular questions that emerged through data analysis.

Also during buddy shifts, I asked questions of informants based on what was happening in the moment. In this way, the buddy shifts were similar to what has been called a "go-along interview" (Carpiano, 2009). Partnering with nurses during their shift provided an opportunity to ask questions about the local area of the hospital and how particular artifacts influenced their practice related to understanding the cognitive function of older patients. The buddy shifts were helpful in identifying ways in which nurses engaged with people and objects in practice, and to explore the nurses' perceptions of those encounters in real time.

The questions I asked were mostly spontaneous and responsive to the situation or emerging interpretations. Over time, certain questions became routine during buddy shifts, such as questions about what nurses thought of particular patient's cognitive function and what led them to that understanding. I also focused questions to gain a better understanding of the environment including relationships, artifacts, and physical space.

During buddy shifts I had a pad of paper with me so I could easily write notes or "jottings" (Emerson, Fretz, & Shaw, 1995) to record the details of what I was observing. Writing notes was particularly helpful when I was asking nurses questions about their practice. It allowed me to capture the essence of the nurses' responses as well as verbatim quotes when possible. Generally, these notes triggered further expansion in field notes after the observation (Emerson et al., 1995; Mulhall, 2003). There were interruptions in the times I could observe, such as if the nurse was working with a younger patient who they did not feel was relevant to my study. In these cases, I used the opportunity to take expanded notes and reflect on interpretations or data collection.

Beyond the collection of data, my actions as a researcher during buddy shifts were of utmost importance as I developed relationships with informants and others I met in the field (Goodwin, Pope, Mort and Smith, 2003; Hammersley & Atkinson, 2007; Spradley, 1979). In order to build rapport and gain the trust and respect of informants, I assisted with nursing activities (such as bed-making, tidying, and retrieving supplies). In most cases I was assisting the nurse with whom I was partnered, but I also helped other nurses when needed. For example, I was often asked to help nurses in isolation rooms by getting them equipment.

Field notes. Extensive field notes were made after observation sessions. After “buddying” with a nurse for a period of time, I proceeded directly to the writing of field notes so that I could record relevant details of the session. The field notes fell into three major categories: descriptive notes, process notes, and analytical notes (Emerson et al., 1995). The descriptive notes were the bulk of the field note data and were comprised of what I observed during the day in as much detail as possible. I also noted elements of the research process that were important to the overall quality of the project, such as decisions about sampling or my thoughts on questions to ask during interviews. Finally, I included notes on possible directions for analysis or possible interpretations of the data.

Interviews. Interviews were conducted to gather information about how informants understood their practice and to expand on what I learned during buddy shifts. Interviews also served as opportunities to explore stories that “stuck with” nurses—experiences in practice that they felt were particular exemplars of how they came to understand the cognitive function of their patients. The interviews in this research provided a valuable opportunity for nurses to reflect on their practice while not constrained by work demands. Interviews were semi-structured, typically with previous buddy shifts as a starting point. I entered interviews with questions to prompt discussion (see sample interview guide in Appendix C), but allowed the informant to determine the direction of the interview (Spradley, 1979). The nature of these interviews evolved as data collection and analysis proceeded. As concepts began to emerge, I focused interviews on clarifying these preliminary interpretations (Spradley, 1979).

All but one of the interviews were digitally recorded (one informant did not want to be recorded, so notes were taken instead). A trained transcriptionist was engaged to

transcribe the recordings. During interviews, I also collected demographic information about informants (the biographic information form can be found attached as Appendix D). The interviews were conducted in locations and at times that were chosen by the informants. Interviews ranged from 30 minutes to 2 hours, with an average around 60 minutes. During interviews, I made sure to tell informants that they could always go “off the record,” wherein the recorder would be turned off and the informant’s comments not noted. There were no instances where nurses chose to go off the record.

Many nurses agreed to participate in both a buddy shift and an interview. In such cases, the most common situation was meeting with a nurse for a buddy shift for 3-4 hours, having 30 to 90 minutes to review my notes and identify questions for the interview, then meeting with the nurse during their break to complete the interview. Follow-up interviews were arranged if breaks provided insufficient time to complete the interview. There were also cases that varied from this structure. Some informants only participated in a buddy shift (4). Several nurses agreed to meet outside of the hospital for interviews (3), in which case we met at a location of their choice such as a coffee shop. Interviews generally occurred within two weeks of the buddy shift, although in one case I was able to interview a nurse several months after our buddy shift when he returned from a leave of absence.

Document analysis. Documents used in nursing practice were also analyzed. Artifacts that nurses used to collect or record information about cognitive function were examined; these included nursing flowsheets, report sheets, patient summaries and care plans. In particular, I explored how information about cognitive function was recorded and how it was used by nurses as they made judgments about the cognitive function of

older patients. The documents were described in field notes and blank copies were obtained when possible. Nurses' perspectives about documents and how they were used were sought from informants during buddy shifts and in interviews, and I observed their use during buddy shifts.

Data Analysis

Focused ethnographies support a short time in the field (in comparison to traditional ethnographies) but are data intensive (Knoblauch, 2005). Because this was a focused ethnography I was particularly focused on one area of practice—how nurses made judgments about the cognitive function of their older patients. However, the theoretical framework guided by notions of phronesis and power meant that I was critically examining nurses' practice and explored various kinds of evidence, the social organization of care, and how relations of power were enacted in practice. As described above, fieldwork for this study provided several types of data, including transcripts of interviews, field notes and copies of documents; there was copious data from which to develop the final results.

Electronic data were managed using NVivo software. As data began to emerge, in the form of field notes and cleaned interview transcripts, I entered them in NVivo. Working from the theoretical foundations of the study and the specific research objectives, an analytic framework was developed to guide analysis (attached as Appendix E). This was done to focus analytic efforts on addressing the research objectives. The analytic framework was converted into a framework of codes in NVivo to be used to assist with data management. Each data element was reviewed and coded according to the framework once it was entered in NVivo.

Analysis began during data collection. Each data record was reviewed and coded as it was completed. The coding helped to organize the data based on the initial analytic framework that centred on understanding concepts, relationships, artifacts and routines. Over time, I modified the coding framework to incorporate emerging trends and refocus data collection. For example, as I came to recognize the importance of discourse around safety, I added an analytic category titled “safety” and two subcategories of “patient safety” and “staff safety” to the framework.

As data collection progressed, I began to form “sensitizing concepts”, tentative interpretations of the data that were used to interrogate data or to drive further clarification with informants (Hammersley & Atkinson, 2007; Spradley, 1979; Streubert & Carpenter, 2010). The emerging interpretations were also recorded in NVivo and were linked to particular pieces of data through the program.

As analysis progressed, I looked for ways that the initial analyses could be further interrogated, seeking to expose possible contradictions, conflicts or alternative explanations. Triangulation was used as an additional analytical strategy to compare data from different sources or from various collection methods in order to challenge and expand interpretations (Hammersley & Atkinson, 2007; Streubert & Carpenter, 2010). This was done both through clarifying interpretations with informants and through analyzing other data sources with new questions. This process served to question interpretations and potentially challenge “how I saw things”. It was important to question my interpretations so that I could be sure the findings reflected the data.

I began to get a sense of the most important elements of the findings and began to write my interpretations in more depth. Through writing, I was able to clarify my

thinking about concepts and relationships, and this provided a foundation for going back to the data to seek further sources to support or counter my interpretations. I particularly sought data that contradicted my interpretations, as a means to deepen my analysis or as the impetus to collect further data in a particular area. Writing was an important part of the analysis process and many iterations of interpretations and preliminary themes were drafted and revised (Hammersley & Atkinson, 2007).

Exiting the Field

While ethnographic fieldwork could (in theory at least) be indefinite, it was important to plan how I would decide when data collection was complete. This study, a focused ethnography, was designed to gather data from a limited field context and to meet a particular purpose (Higginbottom et al., 2013; Knoblauch, 2005). Time spent in the field was regulated by the quality and depth of data collected and by the progress made on analysis. Furthermore, this research was part of a doctoral degree and was therefore limited to the bounds of such a program. Time in the field came to an end after 12 months when analysis began to lead to themes and there was no new data emerging to enrich these findings.

Exiting the field is an important consideration in a focused ethnography. From the beginning of my fieldwork I let informants and other staff know that I would be in the field for a limited amount of time and provided an estimate of how long that might be. I continually endeavoured to ensure staff would have access to my contact information if they had questions after my time in the field ended. Informants gave me their contact information for follow up questions and to have copies of the findings sent to them. At

each unit I concluded with “thank-you” cards and appropriate tokens of appreciation for the staff (e.g. snacks to share during break) over several shifts.

Ensuring Research Quality

There are particular considerations for how research quality is ensured in qualitative research. Research quality may be established by a reflection on the entire research process and an examination of how decisions were made throughout the process (Thorne, Kirkham, & O’Flynn-Magee, 2008). An important consideration in ensuring quality research is providing a coherent theoretical perspective so the research can be held accountable to that perspective (Angen, 2000). Furthermore, quality in qualitative research can be assessed based on various criteria depending on the research perspective used. For this focused ethnographic study informed by a theoretical foundation including notions of phronesis and relations of power, the criteria of reflexivity, credibility and transferability are appropriate criteria.

Reflexivity. When completing ethnographic research, it is important to be reflexive during the research process. I strove to be reflexive throughout the research process, including during planning, data collection and analysis, and used my theoretical framework and research plan as a starting point for decisions.

As the primary researcher and an RN with experience working in acute care, I sought to clarify my position coming to the research and my potential to be particularly inclined to certain interpretations (Angen 2000; Goodwin et al., 2003; Mulhall, 2003). Since beginning my nursing training, I have had an interest in the care of older people, and during my training had a number of opportunities to explore the care of older people in more detail. During my years as a general duty nurse, my experiences focusing on the

care of older people made me particularly attuned to their care, and over time I came to the realization that nursing care of older people in hospital was not what it ought to be. I brought these concerns with me to my graduate training, where I was exposed to theories that helped me understand the difficulties I had experienced, including theories of praxis and how relations of power contribute to nurses' practice in particular health care environments. This combined experience with practice and theory provided the foundation for my doctoral research that was an opportunity for me to scrutinize the care of older people in acute care.

While I did not attempt to completely remove myself from the research, I made an effort to seek and examine interpretations that were unexpected and contrary to my understanding (Higginbottom et al., 2013). I used a journal to document my position and how I sought to question my own assumptions. This journaling of my thoughts, feelings and reactions throughout the research process enabled me to identify areas where I could interrogate the data in new directions. I found this to be particularly useful when I had strong emotional reactions to what I saw in the field. Journaling provided an opportunity to explore the underpinning beliefs that led to my reactions and to identify how they influenced the research process.

Credibility. Another aspect of data quality is the credibility of findings, or ways of assuring confidence in the findings. I used two methods to ensure credibility: member checking and triangulation (Lincoln & Guba, 1985; Onwuegbuzie & Leech, 2007). Member checking is a process of taking findings or interpretations back to members of the group being studied to determine their agreement or gain further information (Hammersley & Atkinson, 2007; Onwuegbuzie & Leech, 2007). Throughout my

fieldwork I sought to clarify interpretations with informants. Often I would identify questions ahead of time to ask during interviews. Informants were able to expand on my interpretations or take ideas in new directions. Triangulation, as noted above, is the process of using various sources and types of data to inform analysis. This included asking different people about the same phenomena to gain multiple perspectives on an issue. It also included using several data collection strategies, such as interviews and observations, to understand a particular issue. Data therefore was used to support other data and provided contrasts that led to further analytic developments. Triangulation was also a means to demonstrate the credibility of findings as multiple sources of data were used to support interpretations.

Transferability. I have sought to make the findings of this research transferable in order to provide opportunities for the findings to be applied to other areas. It is not intended that the results of this study will be generalized to all nursing practice settings or to the work of other professionals. Rather, it is expected that practitioners may be able to use the findings to better understand what is happening in other areas (Lincoln & Guba, 1982; Streubert & Carpenter, 2010). To enhance the transferability of findings, it is important to have a thorough understanding of the place and the people that were the foundation for the study (Lincoln & Guba, 1982; Streubert & Carpenter, 2010). Toward this end, I have provided a detailed description of the research setting and the nurses who participated in the study. Those reading or hearing the research findings can use this information to determine to what extent the research site and informants are similar to those in another area. Ultimately, the findings from this study reflect the particular experiences of nurses in the time and place of the study. While findings will not be

directly applicable to other acute care settings, they may provide new insights into possibilities in other contexts.

Ethical Considerations

Before this research began, approval from the Research Ethics Boards of the University of British Columbia and the health care organization was granted. Moreover, this research was conducted with ongoing attention to potential ethical dilemmas, and with careful forethought about how to address those dilemmas. For this study, it was important to consider the nurse informants, other hospital staff and the older people with whom nurses in this study were working. The ethical considerations centred around four key issues: ensuring privacy, gaining consent, contact with older patients and responsibilities to informants.

Ensuring privacy. This study had particular risks for individuals, one of which was the risk to privacy. Nurses, as well as patients, have the right to expect that their personal information will be protected, including what they choose to share through research. Privacy was particularly important for nurses as they talked about issues that could have implications, real or perceived, for their job security. Furthermore, nurses spoke candidly about their patients so it was critical for me to protect this valuable information.

One area where this was particularly important was how the research data were managed. Measures were in place to protect the names of informants as well as any details in the data that could identify them. Access to the raw data was limited to me and to a transcriptionist trained in protecting privacy. Pseudonyms were used in all subsequent data, including the reporting of findings. Also, details that could identify the

setting and the informants were changed. Electronic data are stored on a password-protected computer and paper data are stored in a locked cabinet. Consent forms are stored in an area apart from the research data. Data with identifying information removed will be kept for at least five years and may be used for secondary analysis. Participants agreed to such use during the consent process.

Gaining consent. When nurses demonstrated interest in becoming informants, I described the research and their potential role in depth. This included the purpose of the research, the research process, what would be expected of them, the potential risks and benefits of engaging in the research, and how the data would be used. This information was also provided in written format through a consent form (staff consent form attached as Appendix F). The informants had opportunities to ask questions before signing the consent form. Each time I met with informants, information about the study was reiterated and they were given the opportunity to ask further questions. This process ensured that the informants knew what to expect and that they were able to decide not to participate in the study at any point. For this study, since I engaged with informants over a period of time, it was essential to have a continual dialogue about their role in the research (Streubert & Carpenter, 2010).

During the research process, I also had contact with hospital staff who were not participating in this research. This included nurses who did not want to participate, as well as other professional and ancillary staff at the hospital. I sought to introduce myself when appropriate, and to explain the research, how I was collecting data and pointing out that I was not collecting data that implicated them.

Contact with older patients. One of the biggest conundrums in this study was completing research in the hospital with older patients who could potentially have cognitive impairments. This was a conundrum because older people, and particularly those with cognitive impairments are often considered vulnerable because they have a limited ability to protect their own interests. This meant that I had to be particularly careful about how I engaged with this population and ensure there were procedures in place to confirm they were treated fairly.

One particular issue related to contact with older people was that of gaining consent. Because I was seeking to review patients' medical records and to be present with nurses during direct care, I sought the consent of patients (patient and family member consent form attached as Appendix G). For many older people in the hospital, their cognitive function was fluctuating. This was one of the areas I was particularly interested in for this research but it also meant that there would be questions about their ability to provide consent to participate in the research. There are significant challenges to gaining consent from older people who may experience cognitive changes (Holt, Siddiqi, & Young, 2008; Mayo & Wallhagen, 2009) but excluding those with cognitive impairments would have meant missing important data that was particularly valuable to this study (Slaughter, Cole, Jennings, & Reimer, 2007). In order to determine how to approach consent in each case, I consulted with nurses who cared for the patient to identify who could and could not provide consent. When the nurse told me a patient was not able to provide consent due to cognitive impairment, I sought consent from their family member (Slaughter et al., 2007). During my time in the field I continually reminded older patients

that I was a researcher and sought their assent to my presence (Slaughter et al., 2007; Streubert & Carpenter, 2010).

Responsibility to informants. As a researcher, there is a responsibility to conduct research so that it is not a burden, and so that informants gain something through participation. One area of concern was how to build and maintain relationships during fieldwork (Streubert & Carpenter, 2010). As previously mentioned, I attended to relationships through helping nurses during buddy shifts, being clear about my time in the field and providing my university contact information for ongoing dialogue about the research. Finally, I shared with participants that I would return to discuss the research findings when the study was complete.

Chapter 5: The Context of Nursing Judgments about Cognitive Function

The findings show that nurses' practical judgments about older patients' cognitive function contribute to a complex understanding of the patient that enables nurses to determine what actions will improve their situation. Practical judgments about cognitive function are socially organized through structures such as documentation systems and social norms, but nurses work within these structures toward the ends of their practice: ensuring safety and securing physiological stability.

In this, the first of four findings chapters, I will describe the context of this focused ethnographic examination of nurses' judgments about cognitive function: the nursing care of older people in hospital. The discussion will include a description of the nursing units, nurses, other hospital staff and patients that comprised the place under examination. I will briefly touch on the physical layout of the units and the routine of nursing practice. Following this general description, I will examine the role of general duty nurses in the hospital. More specifically, I will argue that nurses' roles related to caring for older people in hospital are largely structured around the goals of ensuring safety and physiological stability. This description will provide an important foundation for the discussion in the following three findings chapters.

The main body of the findings is presented in Chapter 6 through Chapter 8. In Chapter 6, I will examine how practical judgments about cognitive function are situated in nurses' interactions with patients. Interactions provide opportunities for dialectic engagement where nurses can gauge patients' responses and determine whether they fit with nurses' expectations of what they consider normal. Practical judgments made

through interactions are an integral part of how nurses are able to enact their practice with older patients.

In Chapter 7, I will describe how practical judgments about cognitive function are structured by the culture of acute care nursing practice as well as the place of nursing within the health care context. Nurses are members of social groups within the hospital and there are particular expectations of them because of their membership in a practice discipline. Practical judgments are used to develop nurses' knowledge that is shared within the discipline. These judgments are guided by socially organized goals in acute care that help shape what action nurses take in practice.

In Chapter 8, I will describe how practical judgments are structured by organizational expectations around reporting and monitoring, which follow the dominant technical-rational model. Nurses artfully act within these structures toward their goals while recognizing the complexity of patients' situations and of their own practice. Taken together, these findings show that nurses' judgments about the cognitive function of older people are highly nuanced and support their actions in practice.

Place: The Hospital Context

Place is integrally important in an examination of culture, and in order to understand nursing practice around how nurses judge the cognitive function of older people in acute care, it is first necessary to explore the foundational elements of the place of acute care. By place, I mean the setting in which nursing practice happens and that is comprised of the people, relationships, social norms, documentation systems, organizational culture, physical space and other elements related to the situated culture of acute care (Poland, Lehoux, Holmes, & Andrews, 2005). In the following section, I will

begin to examine the place of acute care where nurses make judgments about cognitive function of older patients by describing some of the people, relationships, physical spaces, routines and social norms associated with the nursing care of older people in hospital. This description will serve as a foundation for the explanation of how nurses make practical judgments about the cognitive function of older patients in the subsequent chapters.

The research took place at a large urban, publicly funded hospital in a city in Western Canada. Along with various diagnostic and treatment areas, the hospital was divided into units according to medical or surgical specialty (such as orthopedics, thoracics, cardiology, nephrology, general medicine and so on). This research took place on two of those units: “1 South”, a surgical unit that provided care for pre- and post-operative patients who required the services of particular specialists; and “2 North”, a geriatric unit for patients over 70 years old. The physical layout of both units was typical of general hospital units. There was a central nurses station, conference room, medication storage, and clean and dirty utility rooms. Patient rooms were both private and shared, with some rooms able to accommodate four patients. In order to protect the anonymity of study participants, I am not reporting particular aspects of the hospital and study units such as number of beds, elements of the physical space or the specific specialty of the surgical unit. The two units were similar in many ways but also demonstrated important differences related to the populations they served, the types of clinical support available for nurses and differences associated with medical and surgical units. In the following sections, I will discuss some of these similarities and differences.

Older patients. This study was focused on the care of older people in the hospital and both units where the research was conducted had a significant proportion of older patients. The geriatric unit had the explicit mandate to care for people over 70 years old. The surgical unit admitted adult patients of all ages but had a significant proportion of older people (estimates from the Patient Services Manager on the unit was that approximately a third of patients were over 65 years). The patients on the geriatric unit were admitted for medical conditions such as pneumonia, chronic obstructive pulmonary disease, and sepsis. Patients on the surgical unit were admitted prior to surgery and remained after surgery until they could be discharged. Many of these patients had complex medical histories that meant they stayed in hospital for several days or weeks after surgery, and others were relatively healthy and were discharged shortly after surgery. Both units also had what were referred to as “off-service” patients, those who were not under the particular specialty of the unit but were admitted to the unit because there was no bed available for them on the appropriate unit. Therefore, both units from time to time had patients who were different from their regular patients.

The two units regularly had older patients with cognitive conditions such as dementia, delirium or depression. The geriatric unit, however, had a much higher occurrence of cognitive impairments. The majority of patients on the geriatric unit had some form of cognitive impairment and it was not unusual for me to buddy with nurses who were responsible for patients who all had at least one condition with cognitive symptoms. Jana⁵ (RN) commented on how rarely the patients on the geriatric unit were not confused: “I’m always amazed when my patient actually is completely of sound

⁵ All names of study participants have been changed to help ensure anonymity; the names included here are pseudonyms.

mind. Like they have no memory impairment, they're oriented, umm they're able to carry on a completely normal conversation with you, yeah it's astounding". On the surgical unit, most of the cognitive impairments experienced by patients occurred post-operatively, in the form of post-operative delirium, but there were also occasional cases of encephalopathy, dementia, and other conditions with cognitive symptoms.

Hospital staff. There was a large and diverse staff at the hospital that included health care professionals such as nurses, physiotherapists and social workers; unregulated care providers such as Patient Care Aides (PCAs); and ancillary staff from areas such as nutritional services and housekeeping. In the following section, I will describe the role of specific groups that were particularly relevant to this study.

Nurses. The focus of this study was on how nurses made judgments about the cognitive function of older patients. The nurses in this study included general duty Registered Nurses (RN) and Licensed Practical Nurses (LPNs) who were responsible for providing nursing care to patients. The process whereby nurses were given responsibility for the care of particular patients was called the *assignment*, and was similar on the two units. The assignment was completed by the Patient Care Coordinator on weekdays and by a designated "charge nurse" on weekends. Patients were assigned to nurses based on the amount of care they needed so that each nurse would have similar workloads. The assignment reflected the acuity of patients, including their need for intravenous (IV) medications and complex monitoring, as well as their need for assistance with personal care. LPNs were assigned patients with lower acuity than RNs. The assignment reflected the geographic location of patient rooms in only the most general way. Nurses could be assigned patients that were in rooms quite a distance from each other, and patients

sharing one room were often assigned to different nurses. If possible, nurses were assigned the same patients they had cared for on prior shifts.

Nurses worked twelve-hour shifts, around the clock. The day shift began at 7 am and finished at 7 pm, at which time the night shift would work until 7 am the next morning. Most of the support and interdisciplinary staff worked daytime hours, Monday to Friday, so that there was a marked difference on the unit between day shift and night shift. During day shift, and particularly until 5 pm, there were significantly more hospital staff on the unit, including at the nurses' station, in the hallways and in patient rooms. Similarly, diagnostic tests and procedures were mostly done during the day so there was movement of patients on and off the units. On both units, nurses characterized their work as busy. I often heard how they were struggling to keep caught up with their work, including providing care to patients, completing documentation and reviewing new information about patients, such as diagnostic test results and consultations.

In this study, I include LPNs in the categorization of nurses as a “practice discipline” in order to identify a group within acute care with particular roles and responsibilities. There were however important differences in the scope of practice and role of LPNs and RNs in the acute care setting. An example is that RNs had the authority to initiate restraints in an emergency situation, while LPNs did not. In order to recognize these distinctions, I will include the nursing title when identifying data from individual nurses. (Specific characteristics of the study informants were described in Chapter 4: Methods.)

On both units, RNs and LPNs worked together to provide patient care, although there were significantly more RNs at both sites. RNs were generally assigned four

patients during the day, and five at night. LPNs worked independently but were paired with an RN on each shift who supervised them. Together an RN and LPN team would be assigned seven or eight patients during the day, and ten patients at night. The LPN would provide care to four or five patients while the RN would provide care for the others and was also responsible for care that was beyond the scope of practice of the LPN. These numbers fluctuated when there was insufficient staff, the patients on the unit had particularly high care needs, or when patients were waiting to be admitted.

Patient Care Aides (PCAs). PCAs are unregulated care staff without an independent scope of practice. They performed tasks as directed by nurses, largely related to assistance with Activities of Daily Living (ADL) such as toileting, bathing and feeding. On the geriatric unit, there were two PCAs working during the day shift, and one during the night shift. When the unit had particularly high care needs, more PCAs would be brought in to help with ADL care tasks. The surgical unit did not have PCAs as a part of their regular staff, however like the geriatric unit, when the care needs on the unit were particularly high, PCAs were brought in on a temporary basis.

Nursing supports. On both units, there were people who worked alongside the general duty nurses to help the unit run smoothly. Many of the supports were nurses who had a special role in the hospital, such as Patient Care Coordinators (PCC), nurse educators, Care Management Leaders (CML) and nurse clinicians. Unit clerks, while not nurses themselves, also supported general duty nurses. These nursing supports did not have responsibility for direct patient care but worked closely with general duty nurses and supported patient care.

During the day from Monday to Friday, there was a PCC on each unit. On the weekends and on night shifts, a general duty nurse designated as the *charge nurse* would assume the responsibilities of the PCC. The PCCs were responsible for staffing, including ensuring there was adequate staffing and completing the assignment. They were also responsible for coordinating bed allocation with the hospital Access Director, meaning they accepted patients who were being admitted and assigned them a bed on the unit. The PCC liaised with the general duty nurses and maintained an overview of all the patients on the unit. Additionally, they supported discharge planning with the CML, and helped coordinate supplies, cleaning, and maintenance on the unit.

The CML was in charge of arranging for patients' discharge including working with the social worker and patients' family to organize finances, Long Term Care placements and home supports as necessary. Nurse educators worked across several units and supported educating new nurses, and provided support for new clinical procedures or equipment. On the surgical unit, 1 South, there was also a nurse clinician who was the resource person on the unit for clinical procedures and particular clinical needs of individual patients.

The unit clerks worked during the day and evening on both units. They supported the unit by organizing documents in the patients' medical chart, contacting outside resources, coordinating follow-up appointments, ordering tests such as blood work, sending medication orders to pharmacy, and answering the phone.

Interdisciplinary team. Interdisciplinary team members included social workers, physiotherapists, occupational therapists, respiratory therapists, dieticians, physicians and surgeons.

On the surgical unit, each patient was followed by a medical team that consisted of a staff surgeon, and a number of medical residents and medical students. For the most part, the surgical teams were not on the unit; they came around to see patients first thing in the morning and then again in the afternoon, and otherwise were contacted through a paging system. One of the surgical teams included a Nurse Practitioner (NP). Like the rest of the team, the NP was not generally on the unit but could be reached through a page.

On the geriatric unit, the patients were attended by hospitalists (physicians who specialized in the care of hospitalized geriatric patients) as well as residents working with the hospitalists. The hospitalists on 2 North were present more often than the surgical teams on 1 South, although there were fewer of them. Each patient was followed by a hospitalist and, first thing in the morning, the hospitalist or a resident would go around to see each of their assigned patients.

Other medical specialists also attended to the medical needs of patients through consultations. Of note were the geriatric psychiatrists who would be asked to consult on older patients who were experiencing psychiatric complications beyond what the surgical team or hospitalists were able to treat. Often this included patients who were experiencing cognitive impairments.

Nurses' Role in the Hospital

Explaining nurses' practice around how they understood the cognitive function of older patients meant examining their role in acute care and how this shaped their understandings about older people. A significant part of nurses' roles in the acute care environment can be further described through an examination of their goals in practice.

Goals are central to practices and help to guide individuals within the practice toward the valued ends shared by those in the discipline (Cetina, Schatzki, & Von Savigny, 2000). Practical judgments reflect these ends, and nurses determine their actions based on how they perceive the possible actions will contribute to achieving their goals (Benner, Tanner and Chesla, 2009; Sellman, 2000). Values both within nursing and in the wider acute care setting play an integral role in structuring the goals of nurses' practice (Liaschenko, 1994). The goals serve as the desired end point for nursing care and are used to determine best action in practice. Therefore, nurses' deliberations about the cognitive function of their older patients also reflect these goals. The nurses in this study demonstrated that understanding cognitive function of older patients was not an end in this sense, rather it was part of a larger process that would enable nurses to work toward the broader ends of acute caring nursing. The goals themselves reflect how relations of power have been enacted over time to structure what is considered important for nurses' practice. This view of the goals of nursing practice in this acute care setting serves as the foundation for much of what follows throughout the findings. In this next section, I will describe two important nursing goals in the hospital that guided much of nurses' practice around understanding cognitive function: securing physiological stability and ensuring safety.

Although there were some variations between the units about how nurses perceived their role, on both units nurses were essentially seeking to meet the main goals of acute care: to improve the acute condition that brought the patient to the hospital and to ensure nothing happened that might impede their convalescence. On the surgical unit, nurses were focused on the surgical procedure the patient was to have or had recently experienced,

This is more like a surgical floor, you know... it's basically post surgical so... I mean you focus on more... like the surgical procedure. Since they're surgical the assumption is they're really functional you know; they signed the consent, they know they're having surgery. Here is more like the surgical procedure and the post-op and the complications from surgical procedures (Brian, RN).

On the geriatric unit, the nurses perceived their priority to be supporting patients with their ADLs as they recovered from acute medical conditions. "You have to take care of all these like basic things. [This unit] is more like the Activities of Daily Living" (Annie, RN). On both units nurses were focused on the acute needs of their patients.

Ensuring physiological stability. Nurses' practical judgments about the cognitive function of older patients were organized around their understanding of the patient's medical situation and the potential causes of cognitive impairments. Within the acute care system, it was important to understand the cause of medical conditions so that patients could be appropriately treated. When patients experienced cognitive impairments, nurses sought to understand what brought about the condition. This was particularly true when nurses recognized that patients were experiencing acute cognitive changes in the form of delirium: "If it's delirium then it's a symptom" (Lucille, RN). When nurses knew or suspected that patients had delirium, they focused their practice on exploring the potential causes of such a condition. Much of nurses' work with patients who experienced acute confusion was related to determining the medical situation of the patient and identifying any precipitating factors related to the confusion that could be addressed,

We've got to address pain, you've got to address... all their physical needs too because they could be confused because they're... they've got a temp, they could be confused because... there's early sepsis, they can't pee and they need to and we haven't addressed that umm, lots of things (Sylvia, RN).

[Confusion] could be due to infection or it could even be due to just post-up narcotics... or post-op surgery? Do they have withdrawal symptoms, what is it right? You know when was the last time they slept? How long has it been since they actually had a good night's sleep?" (Phillip, RN).

Nurses were aware of the myriad of physiological factors that could contribute to the acute cognitive state of patients. Often the bulk of their practice was spent seeking to better understand the causes of confusion so that nursing actions that would ameliorate the causes could be determined. Practical judgments about cognitive function were aimed toward determining what actions could contribute to patients' physiological stability.

Some nurses identified nursing interventions such as ensuring patients had enough sleep and proper pain management as important to limiting their chances of developing delirium.

I like to be calm with the patient, so just keep a... like settle them early, get them up in the chair, get them something for nausea first and something for pain and get them up in the chair and fix their bed and finally they sleep really well,

because you want them to sleep all night just to get back on schedule (Trish, RN).

However, there was also a sense that little could be done for individual patients who were experiencing acute confusion until the cause of their confusion was understood. Nursing

interventions, such as ensuring sleep or sufficient pain medication, were often secondary to nurses' role in understanding the medical cause of delirium. This was evident in an experience I had while buddying with Michelle. One of her patients had been experiencing increased confusion for the past several shifts and various tests had been ordered to determine the physiological factors contributing to the confusion. The tests included an analysis of the woman's urine that necessitated the nurse obtaining a urine sample. Although the woman was visibly upset, the nurse prioritized collecting the urine sample via catheterization, a procedure that exacerbated the woman's discomfort and triggered her calling out to "stop". The search to understand the cause of the woman's increased confusion took precedence over any nursing intervention to calm her in that moment.

Nurses' knowledge of cognitive conditions, such as dementia or delirium, contributed to their practical judgments about patients' cognitive function. Conditions such as delirium were viewed as symptoms of medical conditions that could be treated. Degenerative conditions such as dementia, however, were viewed very differently because there was no expectation for a cure or an effective medical treatment. In many cases, nurses suggested there was nothing they could do for people with degenerative cognition conditions because there was no acute medical treatments for such diseases: "Yeah, we know he already has advanced dementia and it's not going to get better" (Mandy, RN). Whereas signs of delirium signified to nurses that they needed to act to better understand the cause of the condition, signs of degenerative cognitive conditions such as dementia signified to nurses that they did not need to seek further information about the physiological basis of the condition. Nurses' practice was focused on how they

could contribute to stabilizing the patients' physiological condition. As nurses deliberated about patients' cognitive function, they considered what they would need to do to better the patient's situation. The possibilities for nursing action varied depending on the patient's physiological condition, including the nature of their particular cognitive conditions. Nurses considered evidence about patients' physiological condition particularly important in practical judgments about cognitive function, and their understanding of patients' underlying cognitive conditions gave nurses direction about how to seek such evidence.

Ensuring safety. Nurses' other primary concern in acute care was safety; nurses believed it was their responsibility to ensure the safety of patients, staff, visitors and themselves in the hospital. When talking with nurses about how they understood the cognition of older patients, they regularly referred to the relationship between cognition and safety. "Even though like anyone can have a falls risk, a lot of the time it's the patients that are confused that will have a falls risk" (Annie, RN). Understanding cognitive function seemed at times to be synonymous with understanding safety risk.

It's a major safety issue. It's not just, yeah are they oriented. It's far more than that. It's are they aware to use a call button or will they try to get up on their own, whether it's voluntary in that they want to be independent, so they don't want to call or is it that they've just completely forgotten (Jana, RN).

There was a great deal of emphasis in the hospital on avoiding interpersonal violence, falls or other adverse events that caused harm. This was particularly true for older patients and those who were confused. Nurses sought to understand a patient's safety risk so that they could enact practices that lessened the risk of harm. The focus of

nurses' actions with confused patients was around ensuring they were safe, and practical judgments provided the direction for these actions. For example, at times nurses' practical judgments about cognition led to actions related to medications. Nurses' practical judgments included understanding the nature of particular patients' cognitive changes and responses to treatments.

Let's try to get a PO⁶ med into them when they're mildly, mildly agitated, but not to the point where they're gonna refuse the PO med or they're combative or they're... yeah or they're trying to climb out of bed for the 15th time and they land on the floor (Mandy, RN).

This nurse described how her knowledge of patients and the nature of their cognitive changes contribute to her understanding of the dosing of medication they might need. She suggests that a patient may progress from being "mildly agitated" to "combative" and climbing out of bed if she does not give them the necessary medication at a particular point in time. At other times, nurses' judgments about cognition influenced how much and what kind of surveillance particular patients needed.

Like maybe they've got mobility issues, but because they're cognitively impaired they might try to get up when they shouldn't... [To] a normal person you would say, give us a call first. If they're cognitively impaired they might get up and do it without you and not even think about it (Phillip, RN).

Practical judgments about cognition provided a foundation for how often nurses would attend to patients and whether they would implement safety precautions such as the bed alarm.

⁶ PO is an abbreviation used to refer to medications that are taken orally.

Not only was safety a concern for patients, but nurses also had significant safety concerns for themselves and other hospital staff when patients were confused. Several nurses recounted stories when they themselves had experienced violence or other situations where confused patients acted in ways that could harm hospital staff. Jana (RN) told me about being kicked in the abdomen by a confused patient when she was pregnant and Phillip (RN) told me about a confused patient who got a hold of scissors and was wielding them like a weapon in front of staff. This general perception that confused patients could be harmful to staff meant that nurses were watchful for signs that a patient could be aggressive or violent when they were in a state of confusion. Nurses felt it was their duty to recognize when someone could be violent and to warn others, “I don’t want other people being surprised by his behaviour” (Amber, RN). Practical judgments in such situations were very complex and necessitated nurses use a variety of evidence, such as evidence from family members, their understanding of patients’ medical histories or the outcomes of an orientation assessment, to contribute to their practical judgments about patients’ safety risk.

Safety was an important issue throughout the hospital and potential threats to safety evoked a powerful response from others in the system. For contentious interventions, such as the use of restraints, the presence of acute or degenerative cognitive conditions were powerful in eliciting support for their use. However, understanding whether a patient had a cognitive impairment was not sufficient to understand whether they ought to be restrained. Nurses had to make practical judgments about how the patient’s cognitive function would influence their behaviours, and their potential to cause harm.

Anytime that we get patients who are really impulsive who have like Alzheimer's or severe dementia, uh severe post-op delirium, umm when they come in and they're totally confused, they don't know where they are and they're pulling on things, then it becomes a safety issue for the patient and then 9 times out of 10 we'll call the doctors and we'll say we're concerned about the safety, so then we'll get sock restraints ordered up (Mike, LPN)

I have described two of the main goals of nursing practice in this acute care setting that influence nurses' judgments about cognitive function: ensuring safety and securing physiological stability. These goals will be further elucidated throughout the remaining findings chapters.

Cognitive assessment tools. Given the prominence of formal cognitive assessments in the nursing literature, I paid particularly close attention to how nurses used these kinds of tools in their practice. Nurses' perceptions about their usefulness in acute care nursing practice demonstrated a great deal about how they perceived their role and the goals of their practice in the hospital. Generally, assessment tools did little to support nurses in reaching their goals; while assessment tools could be effective in determining the absence or presence of impairment, they did little to help nurses understand the safety risks or physiological condition of their patients. Nurses' limited use of cognitive assessment tools could, at least in part, be attributed to their inadequacy in contributing to nurses' understandings about which actions would foster the safety and physiological stability of each particular patient.

The only tool I saw, or heard about at the hospital, was the orientation assessment: "the regular questions, you know, what month is it?, what year is it?, why are you here?"

... you know, where are you?” (Caitlin, RN). Many nurses could name other cognitive assessment tools such as the Mini Mental State Exam and the Montreal Cognitive Assessment but most said they had not used them since nursing school: “I’ve never used a cognitive assessment... assessment tool on any ward I’ve ever been in” (Lucille, RN); “Yeah, I’ve never used one in my entire career – in six years I’ve never used the Mini Mental exam” (Mike, LPN). These tools were not part of the practice of general duty nurses. This was despite several tools, such as the Confusion Assessment Method and Montreal Cognitive Assessment, being available to nurses through the internal electronic document system.

Nurses considered cognitive assessment tools to be an advanced form of cognitive assessment, which was beyond the scope of their general duties. Within the acute care context, they felt it was not their responsibility to conduct more advanced cognitive assessments. “I think those kind of tests would be done by the occupational therapist... Yeah so it would be really detailed and that wouldn’t be within my specialty” (Annie, RN). When I asked this nurse more about whether this type of tool would help her practice, she explained that the role of general duty nurses in the hospital did not include considering how patients’ cognitive function would impact their discharge or functional ability beyond their time in the hospital. General duty nurses were focused on the acute needs of patients (i.e. safety and physiological stability) and did not see their role to include preparing the patient for discharge.

I think that those kind of tests are really detailed. I think those are more for umm whether or not that person is able to live independently or if they need to go to a

care home, which isn't really within our scope, because that's like the [Patient Care Coordinator's] job or the discharge nurse (Annie, RN).

Indeed, much of the work planning or organizing discharge was done by the PCC or social worker and particularly the CML, whose primary role was to support patients with discharge. In order to make the unit more efficient, the work related to discharge was reallocated from the role of general duty nurses and had become the role of a specialized nurse. This restructuring, where a particular function that was once a general nursing duty has been given to a specialized nurse, has diminished nurses' perceptions of what they needed to know about their patients (Daykin & Clarke, 2000).

Furthermore, nurses did not perceive their role in the hospital to include diagnosing patients with distinct medical conditions. "A lot of people will do very, very basic... [cognitive] assessments and often that's all we need... I'm not a doctor, I'm not here to do a full assessment" (Phillip, RN). Other members of the health care team had the responsibility to gather more detailed information about cognitive function through advanced assessments. When nurses recognized a patient had a change in cognitive function, they shared their concerns with the medical team responsible for the patient or went through the PCC or charge nurse to ensure the medical team were made aware. Nurses understood that other health care team members were responsible for diagnosing cognitive conditions and implementing the appropriate medical interventions. Nurses' perception was that cognitive assessment tools were used for diagnosis and to monitor very specialized aspects of patients' cognition, and not for nurses' needs. Nurses understood cognitive changes were important to the physiological health of patients and

readily communicated that information with interdisciplinary team members whom they perceived to be responsible for that aspect of the patient's care.

This perception, that it was not the nurses' role to identify cognitive impairments, was present among nurses on both units. I was surprised that even on the geriatric unit, where cognitive impairments were quite common, nurses felt they had no more expertise about understanding cognition than nurses on other units. While the nurses on the geriatric unit acknowledged they likely worked with those with cognitive impairment more often than nurses elsewhere, they said they were no more specialized in providing care that addressed those conditions. When I asked a nurse on the geriatric unit if she thought the nurses on her unit were experts on caring for those with cognitive impairment, she said,

No, but I think we are most frequented. I mean we have the most practical experience, but being... experts on how to manage them, no. But I think we have a lot of good techniques. I just think there could be some better techniques for sure (Amber, RN).

Although the geriatric unit was focused on the care of older people, nurses there did not use cognitive assessment tools any more often than on the surgical unit. Despite having frequent exposure to people with cognitive impairments, the nurses on the geriatric unit did not perceive their role as experts in their care.

In this chapter, I have described the place of nurses' practice in acute care including the physical space, the health care team, and particulars about nurses' routine. Moreover, I have set the stage for a discussion of nurses' practice of understanding cognitive function through practical judgments by discussing two important goals of

nursing practice: ensuring safety and securing physiological stability. Nurses' role understanding the cognitive function of older patients in acute care was further characterized through an examination of how cognitive assessment tools were understood by nurses.

Chapter 6: Situated Interactions

In the following three chapters, I will examine nurses' practical judgments about the cognitive function of older patients as observed and interpreted on the researched acute care units. In this first chapter, I focus on how practical judgments are enacted through situated interactions. Through their interactions with patients (and to a lesser extent family members), nurses gain knowledge that can be used in practical judgments over time to determine what is most important for patients' care. Nurses' actions in practice were reflective of their understanding of patients' particular situations as well as the social organization of acute care. Through interactions, nurses developed a complex understanding of their patient's cognitive function based on conversations, behaviours and responses. Nurses engaged with others to develop an understanding of each patient and their particular situation.

Interactions between nurses and patients were central to understanding nurses' practical judgments. Interactions were organized by the social norms, values and relations of power that were particular to the acute care setting. While social relations organized nurses' practice, nurses acted within those structures toward their goals of practice. Nurses' interactions with patients contributed to their deliberation about what was the best course of action, given the goals in their practice. Throughout this chapter, I will examine nurses' interactions with older patients and how they reflected the social organization of the acute care setting and the particular situation of patients.

Dialectic Engagement

Interactions provided the opportunity for a back and forth exchange between nurses and patients where each was able to respond to the other and nurses could solicit

information toward a better understanding of the patient's cognitive function. Interactions in the hospital were structured and occurred for particular purposes. Nurses worked within those structures to elicit the information they needed to make practical judgments about cognitive function.

Interactions were characterized by dialectic exchanges between people; there was reciprocation where one party acted and the other responded, which contributed to how nurses understood the patient's cognitive function. These exchanges took many forms, including verbal interchanges and non-verbal actions that provided nurses with a way to understand patients' cognition.

The first indication that I have is like body gestures, body positioning and stuff like that. Like how is the patient presenting to me when I walk in and I engage them. ... [From that, I] have a pretty good indication that they're... they're connecting with me and there's some cognition going on (Mike, LPN).

At times this dialectic interaction was a literal conversation. Through conversation, nurses could elicit a response from patients and then use this response to come to a better understanding of their cognitive function. For example, nurses often started their day by introducing themselves to the patient and engaging in a conversation. "...You just kind of just try... generally try and have a conversation with them to see how it goes, kind of follow their lead on where they go with their answers" (Debbie, LPN). The actions of greeting a person and engaging in a conversation could elicit a multitude of responses that nurses used as evidence toward a practical judgment about their cognition. If the patient engaged in a conversation, the nurse might not think about their cognitive function at all, but would move forward with their actions under the

impression that the patient was not experiencing any problems with their cognition. If the conversation did not go as expected however, it might alert nurses to consider cognition more explicitly. “First of all it would just be walking in, saying good morning, having a normal conversation with them and just seeing how they respond” (Kevin, RN).

Other times nurses engaged in dialectic interactions through common rituals in the hospital. Artifacts such as washcloths, thermometers or blood pressure cuffs were often used to elicit behaviours in interactions that nurses could interpret and use as evidence toward their practical judgments. Nurses observed how the patient followed directions related to, for example the equipment used to take vital signs,

When I go in to see my patients, first, I usually do a set of vitals with them, so then you know... I'll ask them give me your arm, put this [thermometer] under your tongue, put this on your finger. If they... if they're with it, they'll follow directions very easily (Kevin, RN).

When this nurse asked a patient to perform a particular action, he was aware of how they responded. If they were able to follow directions, it led him to believe they were “with it”, or cognitively stable. Common interactions that were seemingly meant for a particular purpose, in this case to take vital signs, were also an opportunity for nurses to construct evidence for practical judgments about patients' cognitive function.

Nurses' understandings of cognitive function rarely conformed to models of decision-making that suggest conscious, rational processes. Rather their understandings were embedded in their actions and were not fully conscious (Benner, 2000; Polkinghorne, 2004). “You just kind of go with it, you know like you get an instinct for their [cognitive function] just like through their cooperation and how they react to you...

you know, in what you're doing" (Caitlin, RN). Understanding cognitive function was one part of nursing practice and not necessarily at the forefront of nurses' minds at all times. In fact, much of the process of practical judgment about cognitive function was tacit; nurses were not necessarily aware they were taking in and interpreting information about cognitive function, yet they were able to proceed with actions in practice that reflected their understanding of the patients' cognitive function.

Gauging Normal

Nurses interpreted interactions with patients by considering how they met with the nurses' expectations about what could be considered normal. When talking about how they understood cognitive function through interactions, nurse often used terms such as "normal", "typical" or "appropriate": "Are they acting like somebody who is cognitively normal?" (Lucille, RN). Nurses had expectations about how patients would act in interactions, and when the interaction did not progress as expected, it was a cue that perhaps they should consider the patients' cognition more explicitly, through, for example, performing an orientation assessment. Alternatively, when patients acted in ways that nurses considered normal, it supported judgments that patients did not have any cognitive problems and it would warrant no further action. "If they respond like a normal person would and they engage in a typical conversation then I wouldn't really take it any further" (Kevin, RN).

Nurses made practical judgments about patients' cognitive function through considering socially organized expectations about what was normal in light of what they knew about the particular situation of the patient. Interactions provided an opportunity for nurses to gauge a particular patient's behaviour and whether it reflected what nurses

came to understand as normal for that person in the acute care setting. Interactions however, were also socially organized and nurses' understanding about what was normal was also shaped by values, social norms and cultural meanings. In the following section, I will expand on how nurses drew on their socially organized beliefs about what was normal, as well as their understanding of what was normal for each particular patient, in practical judgments about patients' cognitive function.

The situation of the patient. Nurses gauged whether interactions were normal based on each patient's situation, tailoring their understandings of cognition to the particular case of each individual; their practical judgments were informed by what they knew about the person. Each patient was distinctive and their particular situations were unique and evolving. Nurses adapted their understanding of normal to apply to the particular situation of each patient. For example, Lucille told me about a patient who had a stroke in her twenties, which left residual functional limitations that mimicked symptoms of cognitive impairment, although she was not cognitively impaired. Understanding this women's particular situation meant that the nurse would interpret evidence of cognitive impairment differently than with other patients.

As nurses interacted with patients, they used their understanding of the person to interpret their interactions in practical judgments about their cognitive function. During interactions, nurses questioned their understanding of the person and sought to elicit new information that could augment their judgment of cognition to better reflect the individual. When nurses experienced interactions where a patient's behaviour was out of the ordinary, they made sense of this by exploring what they knew about the patient and

how their behaviours could be explained. For example, a nurse described how she questioned why a patient was refusing crushed medications:

Are they just refusing it because it tastes bad, umm or is there a language barrier issue...? In that case you're assessing more of their behaviour to determine cognitive function... and their diagnosis as well. So are they in with dementia or delirium, is their behaviour... does it look appropriate? (Jana, RN)

The nurse recognized that refusing medications could represent multiple situations: the woman might have misunderstood what they were for, she might have disliked the taste, or it could be a sign of cognitive impairment. These possibilities were evaluated in light of what the nurse knew about the particular patient.

Often nurses had to interpret interactions in the moment by seeking further information and probing the patient for their unique perspective. When I was buddying with Lucille (RN), we walked into a patient's room and he immediately said to us "There are ghosts in that room next door." The nurse engaged in a conversation with the man, asking more about the ghosts in the next room. He told her about his work as a medium and explained how he was trained to speak to spirits. Through engaging with the man in a dialectic interaction, where she was able to elicit information about his situation, the nurse came to understand that his remarks about seeing ghosts were an indication of his spiritual beliefs rather than a hallucination or other cognitive impairment. If she had relied solely on general rules or her previous experiences with patients who had described seeing a ghost, she would have perhaps made a different judgment.

Knowing a person's social background played a role in how nurses interpreted interactions in making practical judgments about patients' cognitive function. Nurses

recognized that a patient's particular history and their experiences influenced how they behaved. For example, an understanding of the patient's educational background could contribute to how nurses interpreted their responses.

You can't really treat a professor, university professor like somebody who is just a high school dropout, you know. Just like their intellectual level, you know, the type of language [they use]. So I don't expect a university professor just to... to ask very simple questions, like you know, like a 12 year old or something. That's then a problem or something's going on, like confusion or something (Brian, RN).

A simple question asked by a university professor could signify a problem with cognition, but when coming from another person, might not. How nurses made sense of interactions was affected by what they knew about the person's social background.

The expertise of family members. Family members were particularly useful in gauging what was normal for each patient given their particular situation. Family, including biological family, friends and others who were close to patients, helped nurses come to practical judgments about the cognitive function of patients. Family members had relationships with patients that gave them a unique perspective on the patient's cognition and nurses were able to draw on that unique expertise through interactions. Family members knew the patient's "normalness" (Trish, RN); they had relationships with patients that reflected a tacit understanding of what was usual for the person, and they could identify changes more readily than those who did not know the person as well. "You get a lot of patients that come in and... their behaviour can be really bizarre, and the family will come in and say 'she's nothing like this, this is all really new.' So that... that's always helpful" (Debbie, LPN).

Nurses' interactions with family members, however, were largely unstructured and nurses generally had to recognize opportunities to learn from family members when they presented themselves. There was little structure in the hospital around how family were included in care. The occasions where nurses' interactions with family contributed to their understanding of cognition were often spontaneous, and interactions were not necessarily planned ahead of time. Many of the interactions between family and nurses happened in the evening. This was because more family seemed to visit in the evening, and the night shift was generally less hectic so nurses had more opportunity to interact with family.

At times, nurses observed family members interact with patients and used their understanding of what constituted a normal interaction to judge the situation. Nurses told me that by witnessing how patients interacted with their families, they could gauge if the interaction was typical for them. Nurses held assumptions that family members would recognize if a patient was not acting in their usual manner and it would affect the quality of the interaction, which was something the nurse would notice. When nurses observed patients having what the nurse considered a normal interaction with their family members, it suggested that the patient was not experiencing any changes in their cognition. "If the patient looks like they are talking to the family and they are calm and they're having a conversation, they're holding a conversation and it just makes me think that they are [cognitively stable]" (Annie, RN).

Nurses also engaged in complex interactions with family members and patients that enabled a nuanced understanding of the patients' cognition that they may not have otherwise developed. Family members' expertise about patients enabled them to act in

ways that evoked responses from patients that were particularly useful in nurses' practical judgments. Although these situations were not common in my time observing at the hospital, an interaction between Amber, a patient named Mr. Fong, and his nephew was particularly compelling. Mr. Fong had a diagnosis of advanced Parkinson's disease and was on an hourly dose of a Parkinson's medication. When Amber (RN) went to his room to give him his 10 pm dose, his nephew was present and spoke to Mr. Fong in Cantonese, Mr. Fong's native language. Previously Amber had not heard Mr. Fong speak but he responded to his nephew, at first with one-word answers. His nephew then got a warm facecloth and briskly washed Mr. Fong's face. This encouraged Mr. Fong to become more alert and soon he was speaking in full sentences. Amber asked his nephew to translate orientation questions and Mr. Fong was able to answer them correctly. She told me later:

We did assessments all weekend – there was no way, like this guy was like completely out of it. But by the time like Monday came around, [we] were like, hey what's going on? This guy, you know, is oriented most of the time you know... [his nephew] did the orientation, I wouldn't have known otherwise.

After seeing Mr. Fong interact with his nephew, and hearing him respond to his nephew's questions, the nurse was able to refine her judgment of his cognitive function; she became more confident that he was aware of his surroundings and his situation. She would not have been able to do this herself, not only because she spoke a different language, but also because the nephew knew a particular way of interacting with the patient that encouraged him to speak.

When it came to interactions with older patients who did not speak English, family members were invaluable to nurses. Judging the cognitive function of patients from ethno-cultural minorities who did not speak the same language as the nurse was a point of uncertainty; “Oh wow, that’s really... it’s one of those difficult situations” (Brian, RN). Linguistic differences between nurses and patients meant that interactions, and particularly verbal interactions, were difficult. Nurses were therefore more reliant on family members to gauge interactions with patients: “I had a lady the other day... she didn’t speak any English at all, but umm the family would always come in and so I’d ask them umm how she was doing” (Mandy, RN). When family was present, nurses took advantage of their knowledge: “If there is a family member, you communicate to the family member and just ask them what’s going on” (Brian, RN).

Interactions between nurses and family members reflected wider values around the role of family in acute care. Nurses did not always welcome family members’ contributions; they voiced their frustrations working with family when they seemingly acted in opposition to health care goals, or sought nurses’ attention when they had little time. Often patients did not have family members present or family would come and leave again without interacting with nurses. As a result, nurses were often conflicted about the value of the presence of family members. However, as informants about patients’ cognitive function, particularly those who did not speak English, family members were critical to nurses’ practical judgments.

The situation of the nurse. I have shown how nurses’ understanding of patients’ normalness reflected each patient’s particular situation; however, nurses’ interpretations of what constituted normal were also socially constructed. Normalcy is constructed over

time by members of a cultural group (O'Rourke & Ceci, 2013) and nurses' positions as members of the acute care culture contributed to how they understood what was normal in interactions with patients. Nurses' understandings of patients' particular situation was important to how they made practical judgments about patients' cognitive function, but patients' actions were also interpreted through nurses' understandings of social norms in the hospital.

Nurses' understanding of normal behaviours in interactions included how they understood the particular emotional responses of patients and whether they considered them appropriate to the particular situation. There was an underlying belief that some emotional reactions were reasonable, but others signified that an individual might not understand what was going on in their environment, which could point to cognitive impairment. When nurses experienced situations where they recognized an emotional response in patients during interactions, they considered the overall situation and what an appropriate response should be. Although nurses recognized that individuals could have different responses to particular situations, they were nonetheless vigilant for responses they felt were out of the range of ordinary and that could signify a cognitive impairment.

If it was something that could seem reasonable that they're angry about something, then... then it might just be... you might just have a bit of an anger issue or you know upset because of how he's feeling right now, but if he's angry about something that seems absolutely ridiculous then that would you know clue us in that there's something a little bit off (Kevin, RN).

Nurses' positions as health care professionals led them to expectations about what was normal for interactions with patients; nurses were accustomed to a particular kind of

interaction in their role as a nurse in the hospital. Their understanding of what those interactions were generally like helped them to recognize when patients knew they were nurses and that they were in a hospital. Trish (RN) described a particular “look” she got from patients that helped her understand their cognitive function as, “looking at you like you’re a nurse.” Nurses’ expectations about how patients acted in the particular context of acute care also included how they interacted with medical equipment and other items common in hospital rooms. Their expectations included how the patient kept their room, and how they navigated complex equipment.

Sometimes you just look at people and you go, hmm, you know. Like especially if like you look at them and the bed’s a mess and their lines are wrapped up and you know you just look at them and go something’s not right. They look like they’ve been caught in a wind turbine you know. You just think something’s not right there, you know (Caitlin, RN).

The patient’s engagement with their surroundings signified to the nurse that there may be something “not right” with the patient’s cognitive function. Nurses’ expectations about patients’ behaviour in the hospital included treating medical equipment with reverence and care. When patients demonstrated they were careless with equipment such as intravenous therapy lines, it could suggest the person was experiencing cognitive changes.

Furthermore, nurses used their experience in the acute care setting to help them decipher whether patients looked typical for their situation in the hospital. The information nurses had about patients’ trajectory in the hospital shaped their expectations. “If they just don’t look good. ...Do they look like a healthy patient? or ... like somebody

who's had surgery and is doing well? or like somebody who is not coping very well?" (Mike, LPN). Knowledge of what a typical surgical patient looked like contributed to how this nurse understood their cognition. A person who had recently had surgery was expected to look and behave in a particular way, and variations from this expectation contributed to nurses questioning the person's cognitive function.

Dealing with Change

Although stability, order and control are often prioritized in acute care, nursing practice and the situations of patients are often unpredictable and changing (Polkinghorne, 2004; Rudge, 2011). The nurses in this study were often faced with uncertainty in their practice and they used interactions to help understand changes in patients' cognition. "Even though a patient's fine right now, guess what in two hours they may not be" (Phillip, RN). Nurses' interactions with patients provided opportunities to recognize changes in cognition that might not be picked up on routine assessments. Through interactions, nurses were able to make practical judgments about their patients' cognitive function that enabled them to act in changing and unpredictable circumstances.

Yeah, I mean sometimes you can't plan for things; you have to take it as it is, you know. Every shift you know, you can't really do it according to yesterday's or previous shift or a week before you know, the situation is changing (Brian, RN).

It was important that interactions with patients occurred over time. During their shift, nurses had several interactions with each patient through which it was often possible to discern changes in their cognition. While nurses generally conducted orientation assessments at the beginning of their shift, they were constantly open to cues about changes in cognition that emerged in their interactions with patients,

I had that guy in the morning and he was calm and cool and he was answering orientation questions, I think he got maybe 2 or 3 out of the 4 of them. And by like late in the afternoon, like getting close to shift change, all this stuff just blew up – his behaviour and his cognition [changed] (Mike, LPN).

Because change was viewed as inevitable in nursing practice, nurses were attuned to possible changes in cognitive function that were expressed through interactions. They developed an impression of what was normal for each patient and were then able to recognize when patients' actions varied from their expectations.

I'll go in and do my assessment during the day and they'll seem completely fine, with it, they'll get up and go you know brush their teeth, wash their face in the morning all independently, umm but over the course of the day they just start doing some abnormal behaviours. From our perspective it seemed as though [a patient] had uh accidentally lost something in the garbage... she took the garbage bin into the room and closed the curtains and started digging through it. So, [I thought]... did she really lose something in her garbage or is she just kind of doing something really weird and then... and then progressively it got worse towards the end of the day (Mike, LPN).

This nurse had made a judgment about the woman's cognitive function early in his shift. Over time, he noticed that his interactions with the woman changed so that eventually, the woman's actions demonstrated to him that she was experiencing an acute change in her cognition.

Collaborators in Care

Nurses' interactions with patients were organized by social relations in the hospital. This included the social background and history of patients and nurses, but it also included assumptions around the purpose of being in acute care. The ends of nursing practice—ensuring safety and physiological stability—played a significant role in how nurses interacted with patients and how they made practical judgments about patients' cognitive function. Nurses were focused on how they would move toward their goals when making judgments and sought an understanding of how patients would collaborate in the effort to meet those goals. One matter that was central to how nurses understood the cognitive function of older patients was the patient's perceived level of cooperation. Nurses understood patients' cognition as playing a role in how patients would work with them throughout the nurses' shift. The practical judgments nurses made about patients' cognitive function reflected how they anticipated the patient would behave and relate to the nurse during that shift so that nurses could “get their work done” (Calnan et al., 2013; Cheek & Gibson, 2003). Nurses' judgments about patients' cognitive function reflected a complex understanding of the patient and their particular situation that helped them determine how the patient would work with nurses towards the goals of acute care.

Nurses often used the word “cooperate” in relation to what was important about the nature of patients' cognition in the context of getting their work done. While cooperation implies a shared effort toward a common goal, nurses in this study used the term in a similar way to “compliance”, in that they described cooperative patients as those who conformed to the wishes of the health care team (Bissonnette, 2008; Vermeire, Hearnshaw, Van Royen, & Denekens, 2001). The use of the word cooperation

demonstrated a value judgment about patients' actions and what was considered good behaviour in the hospital, namely obeying nurses' instructions related to safety and physiological stability. One nurse suggested she could "trust" patients who had sufficient memory to take their medications as she directed:

Will patients remember to take their pills if you leave them at the bedside? Most of the time, at least on my first day, I'll make sure that they've taken their pills with me watching them, umm and then after that umm it depends. I know who I can trust to take their meds and who I can't (Jana, RN).

The word "trust", like cooperate, signifies a value judgment on the part of nurses.

Patients who were working with nurses to ensure they were safe and physiologically stable were doing the right thing, whereas those who did not follow nurses' directions were somehow a problem.

Nurses used their interactions with patients to determine "what kind" of cognitive impairments patients had, and more specifically, how the patient would cooperate with nurses toward ensuring safety and securing physiological stability. Through interactions, nurses sought an understanding of patients' cognition that would help them determine how they would work with the patient that day.

Well, it depends on what the cognitive impairment is. I mean it would really depend on what the issue is. So if it's just that they're cognitively impaired in the sense of not sure what day it is, I mean heck, I've been in the hospital with my wife and I forget what day it is right. Like maybe they've got mobility issues, but because they're cognitively impaired they might try to get up when they shouldn't... There's varying forms of cognitive impairment, right? (Phillip, RN)

For each patient, nurses had to figure out how their cognitive function would contribute to nurses' work. "For every single patient really, you have to check if they're alert and oriented, and how they respond to your questions, how cooperative they are and if they're able to mobilize well" (Annie, RN).

The cognitive function of patients played a significant role in how nurses could work toward ensuring safety and securing physiological stability. For nurses, working toward these ends was often complicated when patients had cognitive impairments. Nurses expressed that working with patients who had cognitive impairments was difficult because they did not cooperate with nurses to ensure the completion of necessary care. One nurse described her work to ensure that a patient with cognitive impairment ate a sufficient amount as an "impossible task" (Amber, RN). Ensuring the patient had sufficient nutritional intake was paramount to the nurses' work: in order to maintain the woman's physiological stability, she needed to eat enough good food.

Nurses characterized the actions of some patients who were confused as "behavioural issues" and described how they affected nurses' ability to complete their work. Behavioural issues included calling out, hitting, biting, scratching, holding the nurses' arm, or other such behaviours, while the nurse was attempting to provide care. The nurses suggested that patients with behavioural issues had a significant impact on their workload, and in comparison to other patients who required a high level of care, those with behavioural issues had a greater impact on their work. "Because even if they're heavy in terms of their care, like they might be a ceiling lift or require feeding or they might be medically unstable, it's so different when you're dealing with behavioural issues" (Jana, RN). Nurses found it hard to get their work done with patients who had

cognitive impairments and who exhibited behavioural issues, and they organized their practice to minimize the effects on their work. Evidence of behavioural issues related to confusion were weighed highly in nurses deliberations about cognitive function. Such evidence reflected nurses' prioritization of evidence that contributed to understanding how they would ensure safety and secure physiological stability, because behavioural issues impeded such endeavours.

Summary

In this chapter, I have discussed how interactions were integral to how nurses made practical judgments about the cognitive function of older patients. Through interactions they were able to construct knowledge to use in deliberations about cognitive function. Nurses interpreted patient behaviours through their understanding of what was considered normal. Understandings about normalness were both reflective of the patients' particular situation and the nurses' socially constructed knowledge of what constituted normal in the hospital. Family members were frequently important to nurses' understanding of what normal meant for particular patients; however, the role of family in acute care was uncertain and family members' interactions with nurses were often unpredictable. Nurses' understandings from interactions were further situated in the values of the acute care setting and reflected the nurses' desire to have patients' cooperation in their efforts to ensure the safety and physiological stability of their patients.

Chapter 7: Membership in a Practice Discipline

Nurses comprise a particular social group in hospital and membership in this group comes with certain cultural knowledge, and is characterized by distinctive social norms and relationships. Nurses, as members of a practice discipline⁷, draw from and contribute to a shared understanding of patients and their care. Nurses, as members of a disciplinary group, had a unique system of meaning, and membership in the group meant that individuals had access to specialized knowledge about cognitive function.

Furthermore, nurses' role in the hospital, which included making judgments about the cognitive function of older patients, enabled them to enact power in particular ways and coordinated their relationships with other hospital staff. Nurses' location in a practice discipline influenced their practical judgments about the cognitive function of older patients and their actions in practice.

Much of nurses' practice in acute care was socially organized and reflected expectations associated with their disciplinary position in the hospital. Documentation systems were integral to how nurses constructed evidence about their patients' cognitive function. Nurses' shared understandings led them to use documents in particular ways that enabled them to meet their goals in practice. These documentation systems largely fit into two interrelated and parallel processes: documentation systems that supported communication between nurses each shift and documentation systems that structured nurses' obligations for reporting and monitoring in the hospital. In this chapter, I will discuss the documentation systems that served as a communication tool among nurses to

⁷ I use the term "discipline" to identify nursing as a entity based on a unique body of knowledge, focused on caring for humans in a particular way (Bishop & Scudder, 1997).

convey specialized nursing knowledge about patients between shifts. Then, in the following chapter, I will further examine the documentation systems used to report and monitor in the hospital, such as the medical chart, flowsheet and Violence Alert. This chapter will largely focus on how nurses' judgments about cognitive function is structured through documentation systems that communicate nursing knowledge but will also explore how nurses act within this structure toward the ends of their practice.

In this chapter, I will describe how nurses' membership in a practice discipline in the hospital structured their understandings about the cognitive function of their older patients. To begin, I will examine the role of documentation systems in how nurses shared knowledge about their patients, including how they developed a reference point about their patients' cognition through reviewing documents and then tested the reference point through interactions over time. I will also discuss how nurses shared information with each other through verbal communication. Furthermore, I will examine how the structure of acute care enabled nurses to draw on their membership in a particular social group to enact power based on judgments about cognitive function.

The Role of Shared Nursing Knowledge

Nursing documentation. Nurses' practice was organized in part by the documentation systems of the acute care setting. Documents not only served as a means to communicate knowledge between members of a group, but they also helped to define what was considered valid knowledge. Furthermore, documents coordinated nurses' actions in practice by shaping how practitioners understood their role within the wider acute care culture. In the following section, I will examine the documentation systems by discussing how nurses used them to share knowledge about patients with other nurses.

The patient summary and report sheet were particular tools that nurses used to share nursing knowledge, and the information they gleaned from these documents contributed to their practical judgments about the cognitive function of older patients. The documents adhered to many of the characteristics valued in technical-rational views of reasoning: they were compartmentalized by body function or system and contained brief descriptions of observable information. They served as an efficient tool to share pertinent patient information necessary to provide care.

Nurses relied heavily on these tools to come to know their patients. Reviewing the patient summary and report sheet was a way for nurses to learn about patients and served as a foundation from which to proceed with their care. These documents gave nurses a sense that they understood the patient, even before they met them. “It helps me in my mind to get organized and ... then I feel I’m ready to go out there and see them” (Trish, RN). In many ways, the patient summary and report sheet were shortcuts for nurses to quickly come to know what was considered the most relevant information about patients. This however, meant that nurses were developing understandings of their patients based on limited evidence that aligned with technical-rational ideals (Malone, 2003).

Each patient had a report sheet and a patient summary and, at the beginning of their shift, nurses sat at the nurses’ station or in other staff areas to review them. Although nurses were still expected to answer call bells and attend to any pressing needs of patients, generally about 20 minutes was dedicated to reviewing documentation. These documents referred to aspects of the patient and their care that were particularly relevant to nursing practice, such as how patients ate or moved and particular tasks nurses had to

complete (e.g. intravenous catheter maintenance, blood work, etc.). Both units had their own preprinted forms; however, there were key similarities across the units.

The report sheet contained information about what was happening with the patient from the previous shift; it was “just a very basic summary of what happened during the day” (Kevin, RN). Toward the end of their shift, each nurse completed one report per patient to pass on information to the next nurse. On the report sheet from 1 South (Figure 1) nurses recorded information about the patient’s cognition under a heading of “LOC” meaning level of consciousness, while on 2 North (Figure 2), there was a heading of “Agitation” where nurses could record particular behaviours related to altered cognition.

Room #	Name	Date / Shift D N	
Special Considerations:			
Neurological:		Respiratory:	
LOC	NVS	Chest	O2
Cardiovascular:			
VS	CVC	Lab Results	Pedal Pulses
Gastro intestinal:			
LBM	Diet	Flatus	
BS	Abd	NG	
Genito-urinary:			
Output	Fluid Balance		
Integumentary:			
Dressings	Skin Integrity	CWMS	Drains

Figure 1: Report sheet from 1 South

Key to abbreviations used in Figure 1: LOC level of consciousness; NVS neuro vital signs; O2 oxygen saturation; VS vital signs; CVC central venous catheter; LBM last bowel movement; BS bowel sounds; abd abdominal assessment; NG nasogastric tube; CWMS colour, warmth, movement, sensation.

During each shift report please state:
Pt. name, diagnosis. Code Status as well as:

Date: _____ Shift: D or N

Mobility: _____

VS (if abnormal): _____

Pain: _____

Agitation: _____

IV/Lines: _____

Foley: _____ Inct: _____ PVR: _____

Tests: _____

Significant Events/Home:

Figure 2: Report sheet from 2 North

Key to abbreviations used in Figure 2: VS vital signs; IV intravenous; Inct incontinent; PVR post-void residual.

Within the areas explicitly about the person’s cognition, nurses often used brief phrases. Particularly when nurses were communicating that there were no concerns with a person’s cognition, they used the abbreviation “A+Ox3”, meaning “alert and oriented to person, place and time”. The phrase was used to signify that a person did not have cognitive impairment and was easily aroused and responsive. “If it says alert and oriented times three that usually means like that person is cognitively intact” (Annie, RN). The phrase “A+Ox3” served to communicate that nurses could expect that the patient would not show any signs of cognitive impairment and the nurse could expect for them to cooperate with care. “If [the nurse records that a patient is] alert and oriented times three then I will go in expecting them to have a... a normal conversation and not to have any cognitive issues” (Kevin, RN). Similarly, nurses used particular terms and phrases to

communicate when older patients were experiencing cognitive impairment. The most common term used to communicate cognitive impairment was “confusion”. “The report sheets will... touch on that. If we have like... if the patient’s confused or just anything that’s about the patient that’s not normally written in the Kardex will be written on the report sheet” (Kevin, RN).

The patient summary concisely described the patient and their trajectory in hospital, including information about the nursing plan of care. The patient summary, often called the Kardex⁸, contained identifying information about the patient, their reason for being in the hospital, and previous medical and surgical histories. When patients were admitted to the unit, a nurse began to fill in the patient summary, often based on what was written in the patient’s medical chart, and each shift thereafter it was updated by the nurse caring for the patient. Although mainly reviewed at the beginning of the shift, nurses continued to refer to them throughout their shift. The documents used for patient summaries varied in some ways between the two units. On 1 South, the patient summary comprised two documents: the patient care plan and the patient care guide. These documents were kept together and both contained information pertinent to how nurses make practical judgment about patients’ cognitive function. Areas that were particularly relevant were titled “Special Considerations” and “Pertinent Medical History” (Figure 3), which was where nurses indicated the presence of cognitive impairments such as dementia or delirium. On 2 North, the patient summary was two double-sided letter sized pages. This form had tick boxes indicating the presence or absence of three cognitive

⁸ Kardex is a term that refers to a specific system of filing patient information and is a registered trademark. Of the documents nurses referred to as the Kardex, not all were officially produced by the holder of the trademark.

The patient summary and report were used by RNs and LPNs almost exclusively, and existed in addition to the patient's formal medical chart. Documentation systems in health care institutions tend to support efforts to create order through objectification and classification (Rudge, 2011), and the patient summary and report encouraged nurses to describe the patient and their care in fixed terms. This was despite a context where change was inevitable. As such, these documents were used to balance an institutional pressure for stability with a flexibility that could be used to account for changes each shift. In comparison to the patient's medical chart, these documents were small, compact and in the case of the patient summary, could be altered each shift. These characteristics made the patient summary and report sheet an efficient way to communicate, a value that was particularly strong in the acute care setting. The documents were physically segregated from the rest of the medical record, which meant that nurses were afforded regular access, but also meant that nurses engaged with two parallel documentation processes.

Developing a reference point. The understanding nurses developed of their patients through the patient summary and report sheet at the beginning of their shift enabled them to develop a reference point they used as a foundation for their subsequent actions in practice. Nurses' practical judgments included the information they got from these documents. Having a tentative understanding of patients at the beginning of their shift before they met them was important for nurses so they could move forward with their practice. "I mean I hate to say stereotyping, you know but just, before you hit the... the bedside, you know, I just like... collect information about what might be" (Brian, RN). This reference point could later be tested through the nurse's interactions with the

patients, but served as the probable truth until they had adequate interactions to make a more nuanced practical judgment. “And sometimes... you’ve only been there for an hour and a half, so sometimes it’s a best guess” (Jana, RN). Essentially, the understanding nurses developed about patients’ cognitive function through reviewing their documentation served as a foundation upon which their practice was based, and which could later be tested through interactions.

Code words. The documents nurses used at the beginning of their shifts were particular technologies that shaped how they understood their patients, and conformed to the ideals of efficiency. They were physically small and only had space for words or short phrases to sum up each “part” of the person. They were quite structured, which is to say they were highly organized and left little room for nurses to contribute outside the required information. The report sheets on both units were compact: on 1 South they were half a legal sized sheet for each person, and on 2 North a letter sized page was divided into quarters, each quarter for a separate shift’s report. Although somewhat different, the patient summaries on both units were compartmentalized so that there was limited space to provide information about each aspect of the person. This compartmentalism perpetuated the notion that patients were readily sectioned into their bodily systems or functions. These compartments also communicated the kind of knowledge it was acceptable to share, while marginalizing other knowledge. Evidence that conformed to traditional scientific values such as observations of patients’ behaviours and the results of assessments were valued and had a place on these documents. Evidence from, for example, patients’ family members or tacit

understandings constructed through interactions, did not have a place to be recorded on these documents.

Within this rigid structure, nurses found ways to share a complex disciplinary understanding of patients. Nurses made the most of the limited space by using code words that had shared meaning within their discipline and that conveyed more information than might at first appear (Berg, Langenberg, Berg, & Kwakkernaat, 1998). As previously described, the phrases “A+Ox3” and “confusion” were often used to directly signify patients’ cognitive function, however, there were many other less explicit ways nurses communicated this kind of information.

The patient summary and report often included descriptors of patient behaviours that were used as code words for cognitive function. Phrases like “climbing out of bed” or “pulling at tubes”, and words like “restless”, “irritated”, “impulsive” or “agitated” were interpreted by nurses as an indication that the patient was cognitively impaired. The following excerpt is from a field note from a buddy shift with an RN:

Amber showed me a report sheet that she thought I might be interested in. Under *Significant Events/Home* it said “hitting and scratching at times, getting agitated”. She explained that this was a good example of how nurses shared information about their patients’ cognition. She told me that this note indicated to her that the man was confused; his behaviours were synonymous with cognitive impairment.

Using phrases about behaviours as code words to indicate cognitive function also happened when people were not experiencing cognitive impairment. Nurses used positive descriptors of patient behaviours as code words that the next nurse need not be concerned about patients’ cognition. “Another thing we write is *pleasant and cooperative*, which

means that they're like very pleasant and cooperative and that you don't have to worry about their cognition as much" (Annie, RN). The words used to describe behaviours were imbued with meaning that were easily understood by other nurses.

Other code words came from descriptors of a patients' mobility. I was sitting with Annie (RN) while she went through the reports and patient summaries for her patients and she pointed to a spot on one that described the patient as a "two-person assist". That generally meant that the person required help from two people to mobilize. She explained to me that when she saw a patient's mobility described as a "two-person assist", it told her that they were "heavy, and likely confused." When I asked her to explain in more depth, she went on to say that describing someone as a two-person assist was less about their mobility than it was indicative of their cognitive function and the heavier workload associated with confusion. Although ostensibly, the words "two-person assist" indicated how much help a person needed to get around, the nurses used this phrase to convey that the person required intense nursing care and that cognitive impairment likely contributed to the increased work.

Other common indicators of cognitive impairment reflected interventions nurses employed when patients were experiencing cognitive impairment, specifically the use of physical or chemical restraints. Restraints were used when patients were likely to cause harm to themselves or others, and a record of their use quickly identified patients who were cognitively impaired. Nurses recorded such interventions in the patient summary and report, and then nurses reading the documents later were able to interpret the presence or absence of these treatments as evidence of the person's cognition. At the beginning of a buddy shift, as a nurse was reviewing a patient's documentation, she said

she had worked with the patient before and he had been confused and physically restrained. She continued to read his report sheet and said, “he must be better because he can get up to the bathroom and isn’t being restrained” (Becky, RN). In this case, the omission of any indication of the restraints and what was recorded about his mobility led the nurse to expect his cognition to be “better”. Similarly, the appearance in the report of neuroleptic medications being used for purposes of sedation indicated to nurses that the patient was likely experiencing cognitive impairment: “Like if someone writes umm yeah ‘climbing out ++ [plus, plus], Nozinan® [levomepromazine] given’, then that will definitely cue me in as in ‘okay this patient will have falls risks, he’s probably confused.’” (Annie, RN).

Nurses relied heavily on the information shared with them by other nurses, however they recognized that the documentation system used to communicate the information had limitations. One nurse described sharing nursing knowledge through documents as a “game of telephone” because “the message gets confused over time” (Caitlin, RN). Nurses could pass information along to other nurses through the report sheet, but there was a chance the message would change with repetition and would lose meaning over time. Other limits of the documents that nurses described included their reliance on other nurses recording the most current information, and having accurate information initially from the patient or their family members on admission. These limits of the report sheet and patient summary described by nurses demonstrate that they were not fully confident in the information the documents provided, and are another reason nurses relied on their interactions with older patients to contribute to their practical judgments about cognitive function.

The place of advanced age. Nurses also treated a patient's age like a code word. There was a shared understanding within nursing that cognitive impairment was common at advanced ages, and nurses normalized cognitive impairment in older patients. As nurses developed a reference point for understanding their patients, seeing an advanced age reported on the patient summary meant their expectations about the patient more readily included cognitive impairments. Then, as they met the patient, their interpretation of how the person acted in interactions reflected the normalized understanding of cognitive impairment in old age. "[We're looking for] all those things... being alert and oriented and cognitively intact for... their age" (Sylvia, RN).

On both units, nurses held assumptions about the relationship between age and cognition that contributed to their understanding that older patients were more likely to have impaired cognitive function. Some nurses spoke freely about their assumptions about age and cognition; one nurse said, "especially in older adults, there's obviously a tendency to think well it's okay that they're confused, because they're 90, they're always confused and I think I do that a lot" (Lucille, RN). Others spoke about situations where older people did not have cognitive impairment and how it went against their expectations. On 1 South, Debbie, an LPN, demonstrated her belief that someone in their nineties was not likely to live at home or be without cognitive impairment. "Ninety-two? I think it's amazing... Yeah, especially if they've got all their faculties and it's amazing how sometimes you can get some people that are in their nineties and they're [independent]." On 2 North, where all patients were over 70 and there was a high prevalence of cognitive impairment, nurses were surprised when patients were not

confused. “It does say a lot about the older population, if they’re oriented times three, that says a lot” (Annie, RN).

The normalization of cognitive impairment in advanced age contributed to how nurses enacted their practice with older people. During a buddy shift with Amber (RN), I observed her work with a patient who was over one hundred years old and who had been identified as being confused. Part way through the day, his son came in and told Amber that the patient’s confusion was new. A week prior he had mild memory loss, but was not confused. Later when Amber and I talked about this experience, she told me that she had assumed that he was always confused because of his age. She said, “when we see him, you know, and we see his age and we see his condition, we just figure that’s how he is.” In this case, information about the man’s age contributed to Amber’s understanding of his cognitive function as chronically impaired, when it was more accurately an acute condition that was potentially treatable.

Although nurses tended to assume older patients had cognitive changes, there were also cases where nurses expressed how their normalization of cognitive impairment in old age led to seeking more information about their cognitive function. One nurse suggested that a patient’s age contributed to how she performed the orientation assessment. Michelle, a relatively novice RN, said she would almost always do an orientation assessment on older patients because she expected them to have cognitive impairments and believed the orientation assessment would contribute valuable evidence toward understanding their cognition.

The benefit of time. Nurses used code words and nursing documents to share nursing knowledge and to help them develop a reference point that served as a foundation

for their practical judgments about patients' cognitive function. This reference point was then tested through their interactions with patients. Over the course of a shift, nurses expanded their understanding of the patient through multiple interactions, using their interactions with patients over time to refine their practical judgments. "I have to take a lot of things at face value and then kind of prove or disprove it later" (Lucille, RN).

For example, although a patient's diagnosis was an important piece of information available in the documentation which contributed to how nurses understood patients' cognitive function, they relied on their interaction with each patient to understand how the condition was manifest for the particular person and how they would work with the patient that shift. "[The diagnosis] doesn't really mean much. I think it just means that for the next 12 hours I'm there, I have to check..." (Annie, RN) In this example, the nurse was referring to a diagnosis of mixed dementia. She went on to explain how she would keep an eye on the patient throughout her shift and take particular note of how they responded and interacted with her. She later concluded, "whether or not they have mixed dementia, how severe it, yeah, you'll eventually find out". She recognized that while the diagnosis was important, she would learn about the patient's particular situation, including what their diagnosis meant for them, through interacting with them over the course of her shift.

Because they had ready access to patients throughout their shift, nurses could question behaviours and then evaluate them later in their shift. Nurses often used several interactions with a person to make a practical judgment about their cognitive function: "[The woman] didn't want to take her sleeping pill, [because] her husband was coming in [but] this was at 9:00pm, and I thought 'uh is he coming in? Are you sure?' But he did

come in” (Trish, RN). This nurse questioned a woman’s reluctance to take her sleeping pill and considered whether this was an indication that she was experiencing cognitive impairment. Over time, she was able to interpret the woman’s actions through future events, namely that the nurse saw the woman’s husband come in as the patient had said. This demonstrated to the nurse that the woman was indeed aware of what was happening and her refusal to take her sleeping pill reflected her particular situation.

Even after having a more significant amount of time to interact with a patient, there were instances in which nurses were not able to make a definitive judgment about their cognitive function.

Nurse: Sometimes it’s a little bit difficult. Sometimes you kind of just wonder all day whether they are or aren’t confused.

Interviewer: Oh do you? Yeah, it’s not exactly a black and white then?

Nurse: Not always. Most of the time it is, but every once in a while there’s the odd case where it’s a bit hard to judge (Kevin, RN).

Ultimately though, if nurses had a reference point that did not indicate cognitive impairments, and the person was not being uncooperative, and allowed nurses to get their work done, the nurses assumed they were cognitively stable.

Verbal communication. Nurses also drew on shared nursing knowledge through verbal communication with each other to learn about the particular situations of older patients. On the units, nurses worked in close proximity to other nurses, and through informal conversations could evoke information to refine their understanding of the patient and the patient’s particular situation, which would in turn contribute to their practical judgments about cognition. Being a member of a practice discipline meant that

nurses could share knowledge particular to their role with others in the same social group. Nurses' interactions with other nurses provided them opportunities to share knowledge through narratives, which then contributed to their practical judgments (Benner, Tanner and Chesla, 2009; Malone, 2003).

If it's not obvious then I might go to someone else and say like, "do you know that person, were you here yesterday, did anyone say anything about this lady, is she all there?" [The other nurse might say,] "Oh yeah, no she... she's totally fine, she was gonna be discharged." "Oh really, I'm finding her a little strange."

(Lucille, RN)

In this example, the nurse is describing what she does when she is not quite sure about a patient's cognition. She would ask another nurse if the patient was "all there"—a term used to mean cognitively stable—and whether anyone else had noted any behaviour that might not be normal. This conversation would be an opportunity for the other nurse to convey her practical judgment, in this case: "she's totally fine". This interaction could then be the basis for further conversation, allowing the nurse to obtain details of the judgment and the nursing knowledge used to come to the judgment.

These exchanges of nursing knowledge often happened in hallways or in other shared spaces on the unit. At one time I witnessed two RNs discussing a patient's behaviour and her cognitive function in the clean utility room. The nurses had both been present when the patient came to the nurses' station in an open hospital gown, exposing her backside. One nurse asked the other if the woman was confused. The second nurse was able to share more information about the patient's particular situation that contributed to her practical judgment of the woman's cognition: the woman was angry

and distracted by her emotions so did not consider the implications of walking through the hallway in an open gown.

While many interactions between nurses happened informally on the unit throughout the course of the shift, there was also an opportunity for nurses to share nursing knowledge at shift change through a *verbal report*. The verbal report was an optional conversation between the nurse ending a shift and the nurse beginning a shift to share nursing knowledge about the patients they were both caring for. The purpose of the verbal report was to share particular elements of the patient's status between the nurses. "We give verbal report if something needs to be watched closely" (Michelle, RN). At times, these conversations included nurses' judgments about patients' cognitive function and particulars of the patients' situation that would help the incoming nurse understand how to care for them. For example, nurses would share how medication helped minimize aggressive behaviours in confused patients, or how patients would get more confused in the evening.

Conversations were opportunities for nurses to use language that they could not use in the medical chart, patient summary or report sheets. Because the written words in the medical chart or report were open to scrutiny from the hospital administration and other health care professionals, nurses felt limited in what they could write. In conversations, nurses had more freedom to use language that may not be appropriate elsewhere. It was during these face-to-face interactions I heard nurses talk about patients having "sundowners", "going crazy" or being "not all there", all of which would not be appropriate for the patients' medical chart because they did not conform to norms of documentation systems that required objective information from observations. Nurses

used these phrases because they were imbued with meaning that other nurses would understand.

Although verbal exchanges were central to how nurses shared specific nursing knowledge with each other, other hospital staff also contributed to nurses' understandings of the cognitive function of patients through sharing information verbally.

The physio or occupational therapists who go in and try to get direction out of someone in a really specific kind of way, then maybe they've had more of that kind of interaction, [I'll ask them] like did you find them confused? (Lucille, RN)

Through verbal communication, nurses were able to solicit information from hospital staff who did not have the authority to contribute such information in formal documentation systems. Patient Care Aides (PCAs) were a very common example of those whom nurses informally asked about patients' cognition. Although PCAs had a particular place in the hospital with a role that did not include assessment of cognition or evaluation of treatments, nurses recognized that they had valuable knowledge that came from interacting with patients. PCAs who spent time with a patient over several days could potentially know the patient quite well. "There's the care aides as well and sometimes it's their third or fourth day, so they do know that kind of stuff about certain patients. They might not know the medical side, but they know the more safety side" (Jana, RN). At one point during my time at the hospital, a nurse wanted to know about a patient's cognitive function and turned to a care aide and asked, "Are they confused?" (Amber, RN). The PCA responded with valuable information about the patients' history of confusion. Although PCAs did not have the authority to make judgments about

cognitive function, they did share information about cognitive function with nurses that contributed to nurses' practical judgments about patients.

Enacting Power through Judgments

Nurses' positions as members of a practice discipline in acute care with a particular, defined role contributed to how they could enact power through practical judgments about cognitive function. Social relations contributed to how practical judgments were organized but nurses acted within those structures towards the ends of their practice. The goals of acute care nursing—ensuring safety and securing physiological stability—empowered nurses to act in particular ways. These goals played a particularly important role in how nurses enacted power through judgments about cognitive function. Furthermore, the social relations organizing aspects of nurses' work in the hospital contributed to how evidence was weighed in practical judgments.

Nurses, as members of a particular social group, were understood to have the knowledge and skills to identify patients who were confused. While the implications of identifying such impairments were wide-ranging, I will explain how nurses could enact power through judgments about cognitive function in two areas: the impetus for more care staff, and initiating the use of restraints.

Nurses' judgments about the cognitive function of older patients were important in terms of how the units were staffed. Patients who were cognitively impaired were considered to be more work than those who did not have cognitive impairments. When there were several patients with cognitive impairments on the unit, and there was a concomitant increase in the work that nurses had to do, there were opportunities to get the help of 'workload' staff. Workload staff included RNs, LPNs and PCAs who would come

to the unit for a specific period of time to assist the regular staff in providing care. The opportunities to get extra help on the unit were rare and when they arose, were often exploited. Nurses' judgments about the cognitive function of older people could be used to enact power related to the allocation of precious resources in the hospital

PCAs were particularly valuable to nurses, whether they were workload staff or regular staff, as was the case on the geriatric unit. They were valued because they took on nurses' tasks, covering what was considered "basic" care work, such as "answering call bells, getting people to the toilet, getting people washed" (Trish, RN). Having extra help with such tasks enabled nurses to complete work that they deemed to be more complex, and that required the advanced knowledge and skills of nurses. For example, one nurse recounted how she spent 40 minutes helping to feed a patient who was confused. She suggested that such work was "not necessarily the best use of health care money" (Jana, RN) and that it would be preferable to have more PCAs on the unit who could perform those tasks. This idea that nurses' work that necessitated prolonged interactions with patients could be passed to unregulated care staff suggests that nurses did not recognize these interactions as opportunities to gather complex knowledge about patients' cognitive function.

Nurses were also able to enact power through initiating the use of restraints for patients who were confused and considered a risk to safety. The use of restraints in the hospital was contentious, with a well known policy indicating that restraints should only be used in rare cases. However, there were many cases where restraints, both chemical and physical, were used to control patients with cognitive impairments and behavioural symptoms. The restraint policy also indicated that it was the authority of physicians to

order the use of restraints in all but emergency cases, but nurses' judgments about the cognitive function of patients could elicit such orders. When nurses determined that patients were cognitively impaired and that there was a threat to their safety or their physiological stability, they could initiate a process that would enable them to use restraints.

Anytime that we get patients who are really impulsive, who have like Alzheimer's or severe dementia, uh severe post-op delirium, umm when they come in and they're totally confused, they don't know where they are and they're pulling on things, then it becomes a safety issue for the patient and then 9 times out of 10 we'll call the doctors and we'll say we're concerned about the safety, so then we'll get sock restraints ordered up and then we go into our whole restraints protocol (Mike, LPN).

Many social relations in acute care, including processes for regulating workload, and ensuring the safety of patients and staff, relied on nurses' judgments about patients' cognitive function. In the context of what nurses described as "busy" units, there was incentive for nurses to weigh evidence indicating a patient was confused and possibly disruptive, more strongly in practical judgments because their judgments would have implications for nurses' responsibilities and workload. The social processes surrounding staffing and restraint use contributed to the prioritization of evidence that indicated patients may be disruptive or uncooperative in care.

Summary

In this chapter I have discussed nurses' position as members of a practice discipline in the acute care setting and what it meant for how they made practical

judgments about their patients' cognitive function. I began by explaining how nurses shared their knowledge of patients' cognitive function through documentation systems and verbal exchanges. Documentation systems were particularly important to how nurses came to understand the cognitive function of older patients and a way for nurses to develop a reference point about their patients' cognitive function that could serve as the foundation for actions until they developed a more nuanced understanding about their patient through interactions. Because nurses had the benefit of working with patients over time, they could test their reference point throughout their shift. Verbal communication was less formal and nurses could share their knowledge through conversations. Finally, I explored how hospital practices around staffing and restraint use could be used to enact power in the hospital.

Chapter 8: Hospital Obligations

Nurses' practical judgments about the cognitive function of their patients were socially organized through their obligations to the hospital. Nurses had obligations not only to patients in the hospital but also to their employers and to other hospital staff. Social relations around how nurses ensured they were accountable and communicated with other health care professionals structured their judgments about cognitive function. However, nurses worked within this structure toward the goals of their practice: ensuring safety and securing physiological stability.

Particularly relevant to understanding hospital obligations were documents nurses used in their practice. In the previous chapter, I examined the documents nurses used to communicate with each other, and in this chapter I will examine how expectations around institutional reporting and monitoring influenced how nurses came to understand older patients' cognitive function. These documents provided structure and guidance about what was important in the hospital, and nurses' work reflected this structure as they made practical judgments that provided the foundation for their practice. I will examine obligations to complete the orientation assessment and Violence Alert in particular, as well as social norms related to the patient's medical chart, and how these documents related to nurses' judgments about cognitive function.

In this chapter, I will examine how nurses' understandings about patients' cognitive function are socially organized through their obligations to the hospital. I will also discuss how the technical-rational model of judgment was dominant in the hospital and how nurses worked outside this model while simultaneously meeting the requirements of their workplace. Throughout this discussion, I will examine how values

of ensuring safety and physiological stability underpin nurses' obligations to the hospital. I will also indicate how documentation systems serve to perpetuate the status quo in the hospital and how they are used to enact power.

The Dominance of Technical Reasoning: The Medical Chart

The patient's chart, or medical record, was a revered document in the hospital that contained a wealth of information about the patient. "Basically anything that's in the chart written by the nurses, the doctors, anesthesiology, physio, anyone, whoever, whatever, any information we can get we love" (Phillip, RN). Its position as a highly regarded artifact meant it was used to enact power in the hospital. In the following section, I will describe the chart and how it structured nurses' practical judgments related to cognitive function. Through this discussion, I will describe how the chart communicated to nurses what was important about older patients and their cognition, and how it was used to perpetuate social roles in the hospital.

A binder for each patient constituted the chart and was kept at the nurses' station. Dividers in the chart separated various kinds of documents such as medical orders, nurses' notes, consultations, laboratory reports, admission information and others. The chart served as the main source of medical and personal information for each patient in the hospital as well as their permanent medical record. The chart was used by nurses to both report elements of their practice and to gather information about the patient from other health care professionals.

The chart was an important artifact for nurses, but its use to support their understanding of the patient was largely unstructured. This was partly because many other health care professionals used it, including doctors, unit clerks, social workers, and

occupational and physical therapists. Nurses were expected to review the chart when they found time, and they sometimes had problems getting access.

There's days I come on and I need the chart and [someone] will walk away with the chart and go somewhere else because it's busy and I'm like where's my chart and then I'm running around looking for my chart, because no one told me they took it into [another] room or whatever and the doctor's looking at it. It... it's very frustrating (Phillip, RN).

Nurses had more opportunity to review the chart on the night shift when there were fewer people around. Each night, nurses were expected to read through the chart and use it to update other documents such as the patient summary. Nurses also reviewed the chart, and particularly, nurses' notes when they were alerted to a particular event in some other way, such as through the report sheet. Some nurses sought to review the chart before beginning each shift. These were often more experienced nurses who were looking for a comprehensive understanding of the patient before seeing them in person.

The most prominent place where nurses contributed to the chart was in the nurses' notes. The nurses' notes were a place where nurses could write a narrative about a particular event so that others could understand what happened, "[The nurses' notes] are usually pretty good if a patient's having a confused episode. Then we can get a much more detailed picture from there" (Kevin, RN). The nurses' notes generally described patient behaviours or the results of assessments, any interventions that were initiated, and possibly an evaluation of the intervention. Very often the nurses' notes were used to record the justification for particular actions a nurse had taken, for example putting the patient in restraints or calling a doctor for an order for a particular medication. The

following is an entry in the nurses' notes regarding a patient who had become confused and was put in restraints: "Patient confused & combative, pulling off O₂, attempted to pull out NG [nasogastric tube] & HMV [hemovac]. Arm restraints put on." Social norms dictated that evidence about patient safety were valid contributions to the patient's medical chart, and contributed to nurses' understanding that ensuring safety was a particularly important aspect of their work.

The chart, including the nurses' notes, contributed to the perpetuation of the status quo in the hospital; there were limits on who could access it and how. There was a hierarchy of hospital staff which could be seen in who had access to information and who did not (Smith, 1990). Within the hospital, it was understood that nurses had the knowledge and skills to interpret information from the chart and to contribute worthwhile information that maintained a particular standard. Patient Care Aides (PCAs), for example, did not have access to the chart—"only the nurses can open that one" (Laura, PCA); they relied on limited information passed on to them by nurses. PCAs spent a great deal of time interacting with patients, and nurses often asked them for information about patients' cognition; however, they did not have the authority to access the chart and the information that it contained.

The chart also communicated what was considered valid knowledge in the hospital. Only particular phenomena could be recorded in the chart and it had to be done in a particular way. It was a technological tool, a place to record objective information gathered from and about patients, as well as a place where health care practitioners shared their rationally deduced conclusions (Poland, Lehoux, Holmes, & Andrews, 2005; Polkinghorne, 2004). Nurses reported patient behaviours, and the outcome of their

orientation assessment as evidence for particular actions they took related to patients' cognitive function. The chart was open to audit, which is to say it was accessible by many health care professionals as well as the hospital administration, who could all potentially criticize what was written (Rudge, 2011). This ubiquitous monitoring served as a way to ensure control over what was written in the chart and limited nurses to write only what adhered to traditional views of scientific evidence. Nurses did not include other kinds of evidence they used in their practical judgments about cognitive function.

Obligations to Report and Monitor: “Assessment for Dummies”

The documents that nurses were required to complete in the hospital communicated to them what was important regarding cognitive assessments; more specifically, a document called the *flowsheet* signified what was important for nurses to understand about a patient's cognitive function. The flowsheet was an important part of understanding the institutional context of nurses' work and how they came to understand their role in judging patients' cognitive function. While the flowsheet was often kept separate from the chart, in another binder along with the vital sign record, fluid balance record, and other documents, it shared many characteristics with the medical chart. The structure of the flowsheet validated particular kinds of evidence while simultaneously marginalizing others. The flowsheet was where nurses recorded their general assessments and what they did with each patient on each shift. Its main purpose was to outline nurses' responsibilities and served as a record of their actions. Speaking about how it related to how she assessed cognitive function, Caitlin (RN) described the flowsheet as “assessments for dummies” because it provided a simple structure that outlined what nurses were required to do to assess their patients.

The flowsheet was the same on both units. It was two double-sided sheets in length and was divided into sections related to body systems on the left axis, with columns for the date and shift along the top. Each section had areas to be assessed or otherwise completed, and nurses could put a check mark next to the areas that were relevant for the patient. For example, there was an area titled “Neuro/Cognition” where nurses were to record their understanding of the patients’ neurological and cognitive function (Figure 5). A large part of this section was devoted to the orientation assessment, which was the only structured assessment tool related to cognition I witnessed being used by nurses.

Use this legend unless another legend is indicated in a section						
Blank Space = Not Applicable ✓ = Assessed / Completed PN = See Progress Notes						
Month (MMM) _____		Date (dd)				
Year (yyyy) _____		Time				
SAFETY	Bedside safety check					
	Bed/chair alarm					
	Increased observations required					
	Falls Protocol in place					
NEURO / COGNITION	Assessed and no difficulty = Alert and oriented, speech clear, appropriate to situation, intact protective reflexes					
	Not oriented to			Person		
				Place		
				Time		
				Situation		
	Inappropriate answers to questions					
	Lack of safety awareness/insight					
See Neurological Vital Signs Record						
See Tube/Drain flowsheet						

Figure 5: Excerpt from flowsheet, 1 South and 2 North

The orientation assessment referred to asking various questions to determine whether a patient was aware of their position in their environment. Nurses assessed four levels of orientation: whether the patients knew themselves, where they were, what the time was and what their situation was. In order to determine a patient’s orientation, nurses asked pointed questions. Amber (RN) explained how they went about the

orientation assessment: “[We ask] do you know where you are? Do you know what year it is? Do you know what month we’re in? When’s your birthday? Who am I? Who’s this person here? Why are you here?”. Generally speaking, nurses interpreted the answers by noting what questions the person “got wrong”. When patients did not know an answer or answered incorrectly, it indicated they were “not oriented” to that part of their circumstances. The flowsheet was then to be used to record the outcome of the orientation assessment under several headings: person, place, time, and situation. The flowsheet communicated to nurses that they needed to complete the orientation assessment and what information they needed in order to do that. Essentially, what nurses needed to record were the actions that were most important to complete (Brown, 2008).

I’ll say my name, “Hi, my name’s Annie, what’s yours?,” so that you get the main part and then you’ll see how well they respond and umm and then I’ll eventually ask them, “Do you know where you are?”. So definitely the alert and oriented [questions] you really ask, because... on our flowsheet we have to mark whether or not they are oriented, so that really... it makes me assess it clearly, because I’m marking it (Annie, RN).

The orientation assessment is a technical tool used to help nurses in making judgments about this one aspect of patients’ cognition. The orientation assessment is structured so that it can be consistently administered, there is a systematic method to interpret the evidence, and the results could be easily communicated to other health care team members. The orientation assessment consists of nurses collecting evidence by asking patients questions, then using their observations to make a judgment about the person in a conscious, linear manner. The flowsheet communicates to nurses that during

their shift, they must collect particular evidence about their patients' orientation status in order to better understand their cognitive function. As a tool to help understand one part of patients' cognitive function, the orientation assessment was a technology that could contribute to nurses' practical judgments about cognitive function, but was not sufficient as a tool to understand the particular situation of the patient or as a foundation for nurses' actions.

Skipping the orientation assessment. Although nurses viewed completing the orientation assessment on the flowsheet as compulsory, they did not always conduct orientation assessments. In many cases they were able to come to practical judgments about a patient's cognitive function by using other kinds of evidence such as those gained through interactions, and without doing the orientation assessment. Doing the orientation assessment was not necessary for nurses to develop an understanding of the patients' cognition that they were confident could be used to determine their actions in practice. When I asked a nurse about whether she did an orientation assessment with one of her patients and she said, "Umm, no I guess I didn't. I [knew]... just by talking with her" (Trish, RN). In the cases where nurses did not do the orientation assessment, they would complete the flowsheet by extrapolating the information it asked for from other nursing knowledge, or from looking at what was recorded on previous days.

There were some cases where nurses' decisions to not conduct the orientation assessment explicitly reflected the complexity of their practice and the moral nature of their actions (Bishop & Scudder, 1997; Tanner, 2006). Nurses contemplated what the best action was for each patient given their particular situation. At times, doing the orientation assessment was not the best course of action for the patient. Nurses had

multiple goals in their practice, only one of which was completing the forms required of them by the hospital each shift. More prominent were the goals to ensure safety and physiological stability. As nurses considered the best action that reflected their overall goals, at times they determined that an orientation assessment would not best serve their patient. For example, I spoke to a nurse about a patient with advanced dementia. She did not do an orientation assessment with the man and said her decision stemmed from a consideration about what the goal of the man's care was and how the assessment would fit into that care.

We know he already has the advanced dementia and it's not going to get better. Umm, I didn't want to agitate him especially before bed... If you're not going to do anything with the information [from an assessment], I don't know. It's not important at this point for his care... His priority is, we want to make sure he gets a good sleep and he's calm (Mandy, RN).

When considered in light of other aspects of his nursing care, the nurse decided not to ask the orientation questions. Her priorities were his physiological stability, through ensuring he had adequate rest, and his safety through ensuring he remained calm. She had made a judgment about the person's cognitive function based on her previous knowledge of him and his particular situation. She suggested that doing an orientation assessment would be superfluous; it would not contribute to how she cared for the man and might have actually disrupted her efforts to maintain his physiological stability and keep him safe.

Validating judgments. In the context of the hospital, where a technical-rational understanding of cognitive function was highly valued, nurses validated their tacit understandings of patient's cognition gained through interactions through the use of the

orientation assessment. Much of nurses' knowledge used to make practical judgments was not readily communicated through formal institutional documents, and was not required in the documents where nurses recorded their actions used each shift. The objective evidence reported in documentation systems to communicate judgments about cognition was valued in the hospital. While nurses used various kinds of evidence to come to practical judgments about their patients' cognitive function, the orientation assessment relied on a single type of evidence valued in the hospital, that which conforms to norms of traditional scientific knowledge. Therefore, nurses used the orientation assessment to validate their judgments based on other kinds of evidence.

In many cases, nurses did not perform an orientation assessment, but would develop practical judgments based on other information; then, if they had noticed anything that did not fit with their expectations they would do the orientation assessment. "If there's anything that seemed a little bit off then I might go digging a bit deeper" (Kevin, RN). When I asked this nurse to explain what he meant by "dig deeper" he said he would do an orientation assessment.

I'd ask them where they are; ask them why they're here. Ask them what year it is, if they can't answer that, what season, what time of day, depending on their ability umm ask them umm what they've had done in the hospital. Ask them you know names of family members and then I go check the chart and see if it's correct, umm just basic stuff like that (Kevin, RN).

By conducting the orientation assessment nurses were able to give credibility to their judgments that were based on other nursing knowledge, such as their interactions with patients. They talked about "getting a gut instinct", sensing something was "off", or

noticing “something weird” as the impetus for performing the orientation assessment.

These statements reflected the nurses’ tacit understanding of the patient, an understanding they had gained through interacting with the person.

I’ve had times where I’ve gone in assuming ... like assuming the person is totally oriented and as you start going through your [general] assessment you’re kind of going, oh wait a minute, something’s not right here. So then you kind of pretend like you were gonna ask him those [orientation] questions all along (Caitlin, RN).

When nurses suspected something was out of the ordinary, they sought evidence from the orientation assessment to give credibility to their practical judgments. Doing the orientation assessment when they had vague notions about cognitive function gave nurses confidence that they could use their judgment in a way that was valid in documentation systems and in communication with other health care professional, namely through reporting the outcome of an orientation assessment.

Tinkering. Evidence from the orientation was at times useful to how nurses made practical judgments about the cognitive function of older patients. However, nurses often made changes to the structure of the orientation assessment in order to get the information they needed to make practical judgments. Their use of the orientation assessment in particular ways depending on individual patients’ circumstances further demonstrates the ways in which nurses’ actions were structured, but not defined by, the documentation systems of the hospital.

While the orientation assessment was valued in the hospital as a means of collecting a particular kind of evidence that could be used to come to a limited conclusion about patients’ cognitive function, in practice, the orientation assessment was not always

straightforward. Nurses found ways to get the information they needed from patients to complete the orientation assessment by skillfully adapting the assessment to their needs. Nurses tinkered with the orientation assessment (Berg, 1999; Mol, 2009), tailoring it to the particular situation they were in with patients in order to get the information they needed, often using non-linear or indirect methods to find ways around challenges they encountered while interpreting responses of older patients.

Much of the time, the answers patients gave to orientation questions were ambiguous and nurses had to interpret their responses to be able to use them to contribute to their understanding of the person's cognitive function. When a patient got an answer wrong, nurses had to determine whether they were actually unaware of their place in the world or if they got answers wrong for other reasons. When patients' answers were unclear, nurses would ask several questions in the same area to get a better idea of their cognition. For example, after a patient got the date wrong, a nurse gave him two answers to choose from: "is it September or October?" (Monica, RN). She explained to me later that many people did not answer the month question correctly and that it did not necessarily reflect their cognitive function.

Nurses acknowledged that being in the hospital could be a disorienting experience for older people and that the hospital environment could affect how patients answered the orientation questions. Disorientation did not necessarily reflect a problematic cognitive condition. Nurses recognized that not knowing answers to the orientation questions at times reflected being in the hospital rather than a cognitive impairment. When patients got questions wrong, nurses gave them opportunities to answer other questions that they believed would better reflect the patient's awareness of their situation.

I find the specific date is kind of a... it doesn't tell you too much, because I mean in the hospital there's no calendars, there's nothing to help with that – everyday looks the same. Umm, so the month I find that a better indicator, umm and then if they're unable to answer that, maybe the season (Mandy, RN).

There were also cases when older patients got orientation questions correct but nurses were not confident that their responses reflected an awareness of their place in the world. “Just sometimes people can know all those things, but still be like kind of confused” (Annie, RN). I noted an impression common among nurses that patients could “memorize” answers to orientation questions, meaning people could give correct answers but the answers did not reflect the person's orientation. “Sometimes like they're good at remembering things, just like... they're good to remember their name, date of birth you know the hospital, but other than that, like their... cognitive functionality is just going down” (Brian, RN). Nurses needed to interpret whether the correct answers were a reflection of the person's awareness of their surroundings or whether they were repeating the answers to the three or four questions they were asked several times over the course of their stay in the hospital. To avoid the possibility that patients were repeating the answers to questions that they were accustomed to hearing, nurses would ask novel questions that the person was not likely to have been asked before.

Part of it is that people often can answer those questions correctly, so sometimes you need to kind of spice it up a bit, so I always throw in like uh what's your birthday or what city were you born in or you know just something that's different. Because a lot of time people can answer those questions, because

they... hear them twice a day or more every day, so you can get pattern, memory pattern build up (Lucille, RN).

For one nurse, however, the fact that a patient had memorized and could repeat the answers to orientation questions was a sign that they were not cognitively impaired. “He knew what was coming so you have to have some insight as to what’s coming to know... to be able to answer that quickly and with humor, so I wasn’t concerned about him last night so much” (Sylvia, RN). The difference was that in Sylvia’s example, the man demonstrated he could use his answers in a humorous way and was not answering the questions out of common repetition. To be able to put together a joke meant that the person had a particular kind of insight that reflected their cognitive function was at a high level.

These examples show nurses had an obligation to complete the orientation assessment, but only gained limited information when they conducted the assessment as specified. They tinkered with the precise method of the orientation assessment in order to gain knowledge that would be useful to their practical judgments about patients’ cognitive function.

Violence Alert

Nurses also had an obligation to other hospital staff who came in contact with patients to share if patients were a risk to safety. Safety was a significant concern in the hospital and part of that was the risk to hospital staff. Because nurses worked closely with patients and had the authority to identify patients who were cognitively impaired, they also had a responsibility to share with other hospital staff the possibility that patients

could be aggressive or violent. The Violence Alert and the corresponding actions, was designed as a way to communicate the risk of violence by patients.

The Violence Alert was a screening tool to determine whether a patient would be violent or aggressive. Although many hospital staff had the authority to initiate a Violence Alert, it was often nurses who started the Violence Alert. The Violence Alert was initiated when a patient demonstrated behaviour that led the nurse to expect the patient could be violent. The expectation was then that the Violence Alert would warn nurses and other hospital staff of the possibility of violence, and actual cases of violence would be avoided. Patient behaviours that were considered risk factors for violent behaviour included Confusion/Disorientation, Agitated/Impulsive, among others. If a patient demonstrated two or more of the risk factors, it indicated a positive screen and a series of actions were taken to communicate the risk of violent behaviours, including posting visual alerts on the patient's identification wristband, their health record, and on the wall outside their room.

Nurses were aware of the potential threats to hospital staff and I witnessed several nurses initiate a Violence Alert for patients who were potentially a risk to staff. However, there was also a perception among nurses that the Violence Alert unfairly labeled older patients, and that the label could lead to negative consequences for them. Part of this attitude came from a perception that it was difficult to have the Violence Alert removed or stopped for patients. When I asked nurses about the interpretation of the Violence Alert signs, they often said that the signs remained after patients' cognition had changed and after the person was no longer at risk for violence. The Violence Alert did not account for the possible changes patients could experience that nurses were so familiar

with. Nurses needed to determine for themselves what the patient was experiencing at any given time.

It's something that needs to be reassessed as their hospital stay continues, because you'll have someone that's completely fine and then they'll be delirious and super combative and be like a different person. We had a patient recently like this and then you can take them off of it again once the delirium clears, because they're back to being just like you and I (Jana, RN).

This nurse went on to explain that it could be a tough decision whether to remove the Violence Alert or let it remain because some people were only confused at night or under certain circumstances. Nurses were aware that when older patients were confused their cognitive function could often fluctuate and would eventually return to normal.

Nurses blamed other nurses for labeling patients with a Violence Alert, particularly when they had different experiences with the patient where they did not feel personally that their safety was threatened. I had spent some time buddying with Debbie, an LPN, who was caring for a woman who was confused, Mrs. Anderson. A few days after the buddy shift, I ran into Debbie on the unit. She immediately said to me, "I have something interesting to tell you: Mrs. Anderson has been put on a Violence Alert." She proceeded to tell me her interpretation of the situation that brought about the Violence Alert. She suggested the woman's aggressive behaviours were likely a reaction to the nurse's approach to caring for the woman. Nurses were aware that the Violence Alert tool could be used to enact power and there was conflict around its use. Nurses sometimes assigned the responsibility for its implementation to other nurses, rather than to the patient.

Nurses recognized that the Violence Alert could contribute to stigmatizing older patients with cognitive function. The culture of acute care had social processes in place that contributed to “othering” and stigma associated with cognitive impairments (Garand, Lingler, Conner, & Dew, 2009; Herrick, Pearcey, & Ross, 1997). Patients came to be considered as “other”—as different from nurses and most patients—through systemic processes such as the Violence Alert. Because of the perceived harm that confused patients could do to nurses and other hospital staff, there was often fear associated with some people who were confused. In the case of the Violence Alert, the label was perceived to be hard to eliminate and was seen as contributing to stigmatizing those with cognitive impairments.

It’s a passing thing, so they get stable... [it could be because of] having an infection or being post anesthetic or having a drug that disagreed with them or being cared for in a way that has violated them or made them feel unsafe or made them feel powerless and then to label them after that or their response of how they’ve been treated is... I find it severely unfair (Amber, RN).

The Violence Alert was a source of tension and conflict for nurses. This tension highlights how nurses can perpetuate social processes that are potentially stigmatizing to those with cognitive impairments because of their concern for safety, despite their awareness that the Violence Alert did not account for the complexity of patients’ cognitive function.

In practice, nurses often disregarded the Violence Alert when they saw the signs that indicated patients had been found to be a risk for violence. When I looked at Mrs. Anderson’s chart and the record sheet that was to be completed by each nurse once the

Violence Alert was initiated, there were no other entries besides the nurse who initially started the protocol, despite there having been at least four other nurses who cared for the woman in that time. Nurses said they often did not notice the Violence Alert warnings they encountered on the unit; the Violence Alert frequently lost meaning for them. When I asked a nurse about what a Violence Alert sign on a patient's chart meant to her, she said she had not noticed it. She went on to explain,

You look at certain things and certain little details... you don't even see them. Yeah maybe you're looking at something else; you know maybe you're just seeing that person and not even just the signs, you know you missed the signs (Amber, RN).

The Violence Alert is a technology that causes conflict for nurses. The conflict related to the use of the Violence Alert derived, in part, from the limited information that could be accounted for through the use of the form. The form did not account for the actions of the nurse in interactions, changes in cognitive function in short periods of time and the possibility of stigmatizing a patient by having a Violence Alert. Using the form as a guide to understand the risk of violent patient behaviours was insufficient for making accurate predictions about future behaviours or to fully understand the complexity of the patient's cognitive function.

The Limits of Communication

The primacy of documentation in acute care and particularly in nursing practice, contributed to nurses' understanding about the limits of what they needed to communicate to other hospital staff. Documents contributed to constraining nurses' practice in the hospital because nurses were unlikely to move outside the bounds of what

was included on the documents to pass on information that did not readily fit within their structure. Nurses did not document much of the knowledge about the cognitive function of patients they gained through interactions. However, they were more likely to move outside the limits of documentation when the evidence related to the safety or physiological stability of patients.

The documents nurses used in their practice were not structured to accommodate the nuances of the practical judgments they made. There was very limited physical space for them to share judgments or nursing knowledge used in deliberations with other nurses. Nurses often had to report on a dichotomous scale; they reported either a presence or absence of a particular element. This limited what nurses could say about any aspect of care they were reporting on the flowsheet.

I think there could be improvement [to documentation]. I mean a lot of time just the [flowsheets], they're not very detailed at all, so it's either you tick it and everything's okay or you have to write long hand in the nurses' notes, which doesn't always happen, so there are some ticks that we can do to just the basic things, like crackles to the lower bases or if... how many bowel movements you've had – all that stuff's on the tick sheet. So we've all got one little 1 cm column down the strip of the page for our... our day shift, which isn't very much (Kevin, RN).

At times, nurses had evidence that was important to their practical judgments about the cognitive function of older patients, but which did not fit into the space allocated for communicating between practitioners. The following example from a field

note shows the challenges a nurse had in communicating information about the cognitive function of an older patient.

Caitlin gave another example of Mr. Smith, that when people see him they would probably say, “he’s 72, oh he’s deconditioned, he probably doesn’t walk much” but she knows him and knows that he’s a black belt in Karate and his brother has a studio and is also a black belt. So for him it’s not at all normal to be in bed. He’s quite active. She wondered how she was meant to pass those things on to other nurses.

This nurse had developed a practical judgment about a patient based on her knowledge of his particular situation but perceived that there was no good way to share this information.

A similar situation occurred during another buddy shift, but had a slightly different outcome based on the nurses’ perception of her role to ensure the physiological stability of the patient. The nurse I was working with had learned a great deal from a patient’s son that contributed to her practical judgment about the patient’s cognition. She had learned what the patient had been like before coming to the hospital: the week prior he had been at a sporting event and had interacted with several prominent community members. Initially she had assumed the man’s confusion was due to a degenerative cognitive condition, but the conversation had led her to change her judgment of the patient and his cognitive function to an understanding that his current confusion was caused by an acute condition. Later when I asked her how she had shared this information with others, she told me she had put a note on the chart for the man’s doctor with the son’s contact information. She said it was important for the doctor to know that the

patient had a recent change in cognition. I then asked how she had shared the knowledge with other nurses, and she said she had not shared it with other nurses. “Well and I think the right thing for me to have done, maybe put a blurb that he’s not at his baseline, which would...maybe give a short... umm like sentence or two about that he was at the hockey game last week and he was fine...”

These two cases are an interesting comparison. In both, the nurse did not communicate important evidence they used to form practical judgments about patients’ cognitive function with other nurses. This supports my argument that the acute care system prioritizes particular types of evidence over others. These cases demonstrated that both knowledge from family and knowledge of the person’s social history were not kinds of evidence that were recorded in formal documentation. However, there is also an interesting difference between these cases that demonstrates the priority of ensuring physiological stability in the hospital. The nurse in the second example wrote a note to the attending physician to let him know about the change in the patients’ cognition from his baseline before coming to hospital. This change, not previously noted in the medical chart, signalled potentially important information about the patient’s physiological health. The nurse passed this information onto the medical team and not to other nurses because she perceived it was outside the nurses’ role to attend to such information. In the first case the patient had developed confusion during his course in the hospital and the medical team were already aware that he had a change from his baseline. In this case, the nurses’ knowledge of the patients’ particular situation would not have any bearing on the medical treatment of his confusion and therefore, she determined it would not be necessary to report the information to the medical team. While knowledge from family

members or about patients' complex social history were generally not considered valid information to report to other health care professionals, when such information was relevant to the patients' physiological stability, nurses found ways to communicate the information to other team members.

Multiple Reports

Nurses' documentation contributed to the smooth running of the hospital system (Rudge, 2011). Nurses worked with many documents in their practice: the patient summary and report sheet discussed in Chapter 7, the flowsheet and nurses' notes, as well as the other documents in the chart. A significant part of their work was ensuring the documentation was completed, and they often recorded information in more than one place. For example, they reported patients' cognitive function on the flowsheet through the orientation assessment, then also on the report sheet. Nurses' communication about the cognitive function of a patient through the report sheet was not sufficient to meet the reporting requirements of the institution. This double reporting meant that nurses had to record the patient's cognitive function twice, in two different locations.

Furthermore, nurses used a third documentation process to ensure the smooth running of their practice. In order for nurses' practice to run smoothly, they needed to have constant access to patient information that was contained in the documentation systems. Information related to patients, such as their medical diagnosis, medical history and treatment plan, were essential to how nurses carried out their work, especially when interacting with other health care professionals. In order to have the information at hand, nurses carried the information on a *cheat sheet*. The cheat sheet differed from the other documents nurses used in their practice because it was developed by the individual nurse

to record information about their patients for that particular shift, and was thrown out by nurses at the end of their shift. Each nurse had their own format for the cheat sheet and determined the specific information they would record. The cheat sheet helped nurses judge cognitive function of older patients through providing information that could be compared with patients' reports to determine if they understood their particular situation:

I said, umm what's your date of birth and then he said his date of birth and... it didn't match what I had on my cheat sheet, so then I found out the guy was umm completely demented and had Alzheimer's and stuff like that (Phillip, RN).

In order to have important patient information at hand on their cheat sheet, nurses had to transcribe information between several documents. This transcription of information followed several steps. First, information was taken from the chart and put in the patient summary at admission and throughout the patient's stay in hospital,

You'd put any medical history, whether they'd have you know a history of surgeries as far as bowel resections, any obstructions, diabetes, so ideally that should all be listed [in the patient summary]... When... I'm first admitting a patient, I'll go through the chart and try and get as much as I can or just ask the patient, you know. That's always the best (Debbie, LPN).

Second, each shift, individual nurses would copy information from the patient summary to their own cheat sheet. Having the information that was deemed most important at hand helped nurses feel confident they would be able to enact their practice; however, the process entailed several steps.

The burden of reporting created challenges for nurses. Nurses were expected to update each individual's patient summary and write a comprehensive summary on the

report sheet each shift. Often that did not happen. Several nurses noted that reports or patient summaries were not updated when they started their shift and recounted how it complicated their work. For example, when I buddied with Heidi (RN), she was frustrated by a nurse who had not written a report, but simply “added to the previous report in different colour ink” (field note). She told me this meant that she did not know the plan for the person’s care and she could not be sure the other information had been updated sufficiently. While nurses engaged in multiple reporting to help ensure the smooth running of the hospital, their practice was often complicated by such processes.

Summary

Through this final findings chapter, I have examined how obligations to the hospital contribute to the social organization of how nurses understand the cognitive function of older patients. The discussion has largely focused on the documentation systems nurses use in the hospital, including patients’ medical charts, the flowsheet and the Violence Alert. The documentation systems privilege objective evidence from observations including the orientation assessment. However, nurses’ interactions with patients demonstrate how they tailor the use of these technologies to the particular situation of the patient so that they can make practical judgments about enacting practice related to cognitive function. Nurses’ obligations to the hospital, including the use of the Violence Alert to ensure safety in the hospital and nurses expectations for multiple reporting, are points of tension for them.

Chapter 9: Discussion

The aim of this study was to examine nurses' practice of judging the cognitive function of older people in hospital through a focused ethnographic study. The findings addressed two research questions: 1) What evidence do nurses use to judge the cognitive function of older people in acute care?, and 2) How is evidence weighed in deliberations about cognitive function? In the following chapter, I will discuss these findings and how they contribute to current scholarship in nursing. To begin, I will provide an overview of the findings.

Overview of Findings

Nurses' practical judgments about the cognitive function of older patients were complex and reflected a nuanced understanding of the person which enabled them to enact care that was relevant to the person's particular situation and effective in supporting patients toward the goals of acute care. Nurses constructed evidence and deliberated about cognitive function over time; they were continuously open to new evidence about cognitive function that might indicate change or previously hidden impairments and incorporated emerging evidence into their judgments. Nurses' practical judgments about cognitive function reflected their role in the acute care setting and how they understood their role of caring for older people. In practical judgments about cognitive function, nurses weighed evidence based on how it contributed to meeting the goals of their practice, namely ensuring the safety of patients and staff, and securing the physiological stability of patients so they could be discharged from hospital.

Evidence. Nurses used many kinds of evidence in their deliberations about the cognitive function of older people in hospital. Social relations, including documentation

systems, social norms and rituals, structured the knowledge nurses constructed about the cognitive function of older people. Evidence used in practical judgments about cognitive function came from two interrelated and connected sources: interactions with patients and their family members, and shared information from other health care staff, particularly other nurses.

Interactions with patients. Nurses used evidence they constructed through their interactions with patients and family members in practical judgments about the cognitive function of older patients. Because nurses interacted with a patient many times over the course of their shift, they were particularly attuned to patient behaviours that could indicate changes in their cognitive function. Much of the interpretation of patients' behaviours was tacit; nurses engaged with patients in routine rituals in the hospital that were not overtly focused on assessing cognitive function, such as greeting the patient, taking vital signs, or doing a general assessment. These interactions, while routine, were opportunities for nurses to gauge patients' responses, and to interpret them to be used as evidence in practical judgments about the patient's cognitive function. During interactions, nurses were attuned to whether anything was "off" or "not right," which could indicate that patients were experiencing problems with their cognitive function. For example, nurses indicated that if patients did not follow directions or did not know what to do with a object, such as a fork, it would indicate that they might be experiencing changes in their cognition.

Nurses' interactions with patients' family members were also used as evidence toward practical judgments about cognitive function. Family members were understood to be experts about a patient's cognitive function, and nurses observed family-patient

interactions for indications that patients' cognitive function was different from what their family expected. Nurses also asked family members about patients' cognitive function and relied on them to report any changes they noted.

During interactions with patients, nurses often performed the orientation assessment, a technical tool used to determine patients' awareness of their surroundings, to learn about their cognitive function. Nurses often used the orientation assessment in circumstances where they had indications from documentation, such as the report sheet or patient summary, that the patient had the potential for cognitive impairment, or when they noticed the patient acting "abnormally", as a way to validate their tacit interpretations of the patient's behaviour. The orientation assessment results were required in the documentation nurses completed each shift. Although obligated to document the outcome of the orientation assessment, nurses did not always complete the assessment, and instead extrapolated the information from what they learned about patients through other sources, such as how the patient responded in conversations or common rituals. Furthermore, when nurses conducted the orientation assessment, they often tinkered with the format to accommodate the particular situation of the patient, such as giving the patient a number of response options, rather than using open-ended questions. Tinkering enabled nurses to construct knowledge about patients and their particular situations that contributed to nurses' complex judgments about the patients' cognitive function.

Shared knowledge. Nurses also learned about patients' cognitive function from other hospital staff, including other health care professionals, unregulated care staff and, primarily, other nurses. One way that nurses drew on information from other health care

professionals was through documentation systems. The report and patient summary served as the main method of communication among nurses each shift. These documents served as a framework to share information about patients that was specific to providing nursing care for each patient. Nurses not only recorded explicit information about patients' cognitive function on these documents (e.g. existing cognitive conditions or orientation status), but they also used code words and phrases to convey the complexity of patients' cognitive function. For example, nurses reported particular patient behaviours that were attributed to cognitive impairments, and medications or interventions they had initiated to keep confused patients safe. This information was included in nurses' deliberations about the patient's cognitive function and contributed to a highly nuanced understanding of the patient that served as a foundation for nurses' actions.

Other documentation systems also provided evidence for nurses' practical judgments about older patients' cognitive function. However, they were often more difficult to access. The patient's medical chart, including documents such as nurses' notes, physician consultations and laboratory reports, had information that was, at times, used by nurses in deliberations about cognitive function. Only particular kinds of evidence were considered valid for including in documentation, such as behavioural observations or formal assessments results such as the orientation assessment.

Formal and informal conversations between nurses and other hospital staff also contributed to nurses' practical judgments about cognitive function. Nurses shared information about patients with other nurses through a verbal report at shift change, and these exchanges were an opportunity to provide information that did not fit the social norms governing documentation. Nurses also sought information from other hospital staff

in informal exchanges throughout their shifts, including information from other nurses, health care professionals and Patient Care Aides (PCAs).

Weighing evidence in practical judgments about cognitive function. Nurses weighed evidence about the cognitive function of older patients based on how it supported their work toward the goals of nursing practice in acute care: ensuring the safety of patients and staff, and establishing the physiological stability of patients so they could be discharged. Indications that patients' behaviours could be risks to the safety of themselves or others, or evidence about acute physiological changes were weighed heavily in practical judgments about cognitive function. The extent to which patients were perceived to be cooperative was an important part of how nurses understood the cognitive function of older patients, and reflected aspects such as the patients' ability to understand their circumstances and to engage with nurses toward staying safe and bettering their health. Evidence that patients were not cooperative with nurses' efforts to ensure safety and secure physiological stability was very important to nurses' judgments about their cognitive function.

Evidence that conformed to traditional understandings of scientific knowledge, such as the results of laboratory tests, medical diagnoses, and the results of formal cognitive assessments, were weighed along with other evidence such as experiential evidence gained through interaction, and evidence gained from family members. Alone, traditional scientific knowledge was insufficient to provide nurses with adequate evidence to confidently understand the nuances of a patient's cognitive function that would enable them to determine how to act toward meeting their acute care nursing goals. However, scientific knowledge such as the results of the orientation assessment

were useful as nurses communicated with other health care professionals, such as when nurses spoke to doctors regarding initiating the use of restraints.

Discussion of Major Findings

In the following section, I will further explain these findings and demonstrate how they contribute to current discourses in gerontological nursing scholarship. The discussion will be presented in four sections reflective of the main findings: 1) the complexity of nurses' understanding of cognitive function; 2) the structuring of judgments through documentation systems; 3) the invisibility of nursing knowledge; and 4) the role of nurses in acute care for older people.

The complexity of nurses' understanding of cognitive function. As defined in Chapter 1, cognition is a part of mental functioning related to knowledge and thinking, and includes such elements as attention, orientation, level of consciousness, memory, concentration, judgment and abstract reasoning. As such, cognitive function is integral to the general function of older people in hospital. Cognition supports older patients in hospital as they interact with others, understand their health situation, and act to maintain and improve their circumstances. Nurses' understanding of older patients' cognitive function is important to how they enact care and engage with patients throughout their stay in hospital. Moreover, nurses' understandings of older patients' cognitive function enables them to improve the health of older patients in a way that reflects the person's particular situation. Nurses' judgments about patients' cognitive function are complex and reflect a nuanced interpretation of each patient's circumstances.

Cognitive function has many facets, and nurses sought a complex, integrated understanding of how the facets were displayed in each particular patient. An example

from a nurse in this study was determining if a patient would remember to ring the call bell when they needed to get out of bed. Nurses' understanding of the patient's ability to complete such a task reflected the patient's memory, judgment and attention. This way of understanding cognitive function is different than what is portrayed in nursing literature. Nursing scholars tend to focus on the recognition of cognitive impairments (e.g. McCarthy, 2003b; Moyle, Olorenshaw, Wallis, & Borbasi, 2008; Steis & Fick, 2008) and have generally neglected to account for how nurses understand the full complexity of cognitive function.

A complex understanding of cognitive function was necessary for nurses to determine how to provide care that would improve patients' situations. Nurses' actions in practice were reflective of their understanding of the patients' cognitive function, as well as their understanding of how to best reach the goals of their practice given the patients' particular situation. The nurses in this study demonstrated that their perceived role was to ensure patients were safe and physiologically stable. This meant the actions nurses took to improve the situation of patients were oriented toward these two goals, and their understanding about patients' cognitive function helped them to determine what actions would bring the patient closer to reaching these goals. For example, a nurse in this study understood that a patient who was confused needed sleep to help maintain their physiological stability and prioritized the patient's rest over performing additional assessments.

Gerontological nursing work has at times been oversimplified and particular elements of their work, such as bathing, feeding or toileting, have been described as basic nursing (Deschodt, de Casterlé, & Milisen, 2010; Herdman, 2002). This study however,

has shown the complexity of nurses' work with older people and the highly nuanced understanding of cognitive function on which it is based. Several scholars have noted the tendency of staff on acute care units to focus on the efficient completion of particular tasks, rather than more individualized care (Calnan et al., 2013; Daykin & Clarke, 2000). For example, Calnan and colleagues conducted an ethnographic study that demonstrated how care staff focused on organizing work that "allowed staff to get things done in the quickest and easiest way" (2013, p. 478). Describing work in this way, as task-oriented, suggests work that is routinized and mechanical, and obscures the possibility it could be based on complex judgments. The care of older people, and particularly those with dementia, has often been described in this way in the literature (Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2011). However, this study has demonstrated that many of the tasks that nurses complete, while not outwardly appearing to require a great deal of education or training, actually rely on a complex understanding of cognitive function.

The nurses in this study used various kinds of knowledge in deliberations to develop such complex understandings of older patients' cognitive function. This knowledge included information from documentation systems about current and previous medical conditions, such as diagnoses of dementia, delirium and other conditions with cognitive symptoms. Information about a patient's diagnoses contributed directly to nurses' understanding of their cognitive function so that a diagnosis of advanced dementia, for example, would indicate to a nurse that the patient might be unresponsive. Patients' diagnoses also contributed to how nurses determined their actions, such as how they sought new information about their patients' cognition. For example, a diagnosis of dementia suggested to nurses that it was not necessary to look for physiological

foundations for the patient's confusion, while indications that the patient had delirium would lead nurses to seek information about physiological conditions that might have contributed to the onset of delirium. This reflected nurses' understanding that delirium was often reversible while dementia was not. Similarly, other scholars have suggested that nurses' understanding of the cause of cognitive impairment, particularly dementia or delirium, affects how they enact care (McCarthy, 2003b; Moyle et al., 2011). This study builds on such work by demonstrating that understanding cognitive conditions is only one part of nurses' sophisticated deliberations toward a complex practical judgment of cognitive function. Diagnoses of conditions with cognitive symptoms, along with nurses' understanding about those conditions, helped them determine how to seek further evidence about cognitive function and potential precedents to the condition, but was not enough information to alone develop a complex understanding of a patient's cognitive function. For example, one nurse suggested that a diagnosis of mixed dementia did not tell her much about how a patient would interact with her, and she therefore needed to continue to construct evidence about their cognitive function through interactions over time.

The findings from this study demonstrate that interactions with patients were particularly important as a source of evidence in judgments that led to a nuanced understanding of patients' cognitive function, and hence provided a foundation for actions to improve the patient's situation. This supports the work of nursing theorists who have articulated the importance of interactions to how nurses determine their actions in practice (Benner, Tanner, & Chesla, 2009; Liaschenko, 1994; Malone, 2003). Through interactions, nurses constructed various kinds of evidence to use in deliberations about

cognitive function, including evidence about how patients used artifacts, conversed with family and followed directions. My finding that nurses used interactions with patients to develop a complex understanding of cognitive function aligns with other scholars who argue that nurses' proximity to patients, during intimate care acts, for example, is important to how they are able to understand their patients' situations (Malone, 2003; Twigg, 2000).

Furthermore, the findings show the importance of nurses' engagement with patients over time to practical judgments about patients' complex cognitive function. This finding builds on the work of other theorists who have suggested nurses learn about patients and how they will engage with them over time (Benner et al., 2009; Malone, 2003; Moser, 2010). These scholars have noted that being near patients and understanding their particular narratives helps nurses to understand how to place importance on various aspects of their care. Benner et al. (2009) note that having many interactions with patients over time helps nurses recognize changes, or "transitions", in their status. The nurses' actions in the current study supported this idea when they demonstrated how they depended on interactions to recognize acute changes in cognition. This study expands on articulations of the importance of time in nursing practice, by showing how nurses "test" their understandings of a persons' cognitive function over time. The nurses in this study were attuned to cues from patients that might indicate cognitive impairment, and gauged their behaviours on repeated occasions to determine what these patterns of behaviour indicated about cognitive function.

The orientation assessment was also important to how nurses developed an understanding of patients' cognitive function, and unlike other screening tools, was used

consistently by nurses. The orientation assessment was a tool used to determine patients' awareness of their situation and was required in formal documentation systems (i.e. the flowsheet). It was completed through a particular kind of interaction with patients, which included asking questions about the four levels of orientation: awareness of person, place, time and situation. The findings from this study demonstrate how nurses "tinkered" with the orientation assessment to tailor the questions to the patient's particular circumstances, which helped the nurse to develop a more nuanced understanding of the patients' cognitive function than following the orientation assessment format more faithfully. For example, nurses said they often asked multiple questions to understand one level of orientation. Although the orientation assessment is generally dismissed in the literature as an insufficient method for assessing cognitive function (Mezey, Fulmer, & Abraham, 2003; Palmateer & McCartney, 1985; Souder & O'Sullivan, 2000), some scholars suggest that it can be a way to identify a need for further investigation (O'Keeffe, Mukhtar & O'Keeffe, 2011). This study supports the idea that the orientation assessment provides some utility for nurses, and moreover, demonstrates that tinkering with the assessment makes it better for developing a complex understanding of the patient's cognitive function.

While the knowledge used in nursing has often been presented as a dichotomy, either drawing on scientific discourses or caring discourses (Canam, 2008), this study demonstrates that there are many kinds of knowledge used by nurses in judgments about cognitive function. The evidence is knitted together and integrated, in order to develop a nuanced understanding that can inform nurses' practice. Clinical guidelines generally suggest the use of cognitive assessment tools as the primary means to assess cognitive

function (Doerflinger, 2007; Milisen, Braes, & Foreman, 2012; Registered Nurses' Association of Ontario, 2010; Waszynski, 2001). The orientation assessment is an example of how assessment tools may be better conceptualized as part of the broader process of practical judgment, as a tool that can provide valued evidence about the cognitive function of older people, yet is weighed against other evidence about the person gleaned from interactions, family members and other clinical knowledge, none of which is sufficient on its own to establish a complex understanding of cognitive function from which to determine nurses' actions.

The structuring of judgments through documentation systems.

Documentation systems were important structural influences on the way nurses made practical judgments about the cognitive function of their older patients; documents played a role in how nurses constructed evidence and in how they weighed evidence in judgments. The findings demonstrate that nurses used several documentation systems in their practice, each of which had a different function and purpose. The documents that were found to be relevant to nurses' practice judging the cognitive function of older patients included the patient summary, report sheet, cheat sheet, Violence Alert, and the patient's medical chart, and more specifically, the nurses' notes and flowsheet. Four of the documents were particularly useful to nurses as they made practical judgments about their patients' cognitive function, and also contributed to the complexity of nurses' practice: the patient summary, report sheet, flowsheet, and cheat sheet.

The patient summary and report sheet were integral to how nurses judged patients' cognitive function. These documents were a way for nurses to share important nursing knowledge each shift and to maintain a record of each patient's particular

situation from a nursing perspective. The patient summary contained information such as the patients' medical diagnoses, medical history, functional status summary, including any assistance they needed with Activities of Daily Living (ADL), and the status of nursing interventions such as dressings and intravenous line maintenance. While the patient summary often contained explicit mention of conditions that might play a role in patients' cognitive function, nurses also found information to inform their judgments from less explicit sources, such as patients' mobility status and general functional ability. Often the words and phrases on the patient summary were imbued with meaning shared among nurses, what I have called "code words".

Nurses needed to update the patient summary each shift to ensure it contained relevant information about patients and their current situation. However, nurses were not always able to update the patient summary and this led to challenges for other nurses in constructing reliable evidence about patients' cognitive function. Dahlke, Phinney, Hall, Rodney, and Baumbusch (2014) also found the patient summary essential to nurses' work in caring for older people in acute care, and additionally noted a conflict surrounding its use because of the commitment required in order for nurses to maintain current and valid information. Ultimately, nurses used the information from the patient summary tentatively in judgments about patients' cognitive function.

The report sheet was also used to convey knowledge among nurses. The report sheet was a means for passing on information particular to each shift to the next nurse; it was therefore a reflection of the patients' recent past. The report sheets were small (less than a page) and had defined areas to report particular aspects of each patient's care. Malone (2003) describes how nurses' communication between shifts about particular

patients once took the form of a narrative written in the nurses' notes. Berg (1999) argues that freeform text, without a great deal of structure, is useful in sharing meaning among health care practitioners because they can decide what is important to include, and select words and phrases that signify the particular meaning they wish to convey. Although the nurses in this study only had a small area of structured space in both the report sheet and patient summary, they used words and phrases that held particular meaning to communicate with other nurses. They shared their complex understandings of patients through codes words and phrases such as "A+Ox3" (alert and oriented on three levels) and brief descriptions of patient behaviours (such as "agitated" or "crawling out of bed"). Despite the use of code words, there was still a great deal of information that was not shared through the report sheet and patient summary. This information might be reported in other areas of the chart, such as the nurses' notes or medical notes, but nurses were less likely to review those documents at the beginning of their shift than they were to review the patient summary and report sheet. Nurses relied on these documents at the beginning of their shift in order to develop a frame of reference for understanding their patients, which served as the foundation for their practice.

The flowsheet was another document that structured nurses' understandings about the cognitive function of older people. Although the flowsheet did not regularly contribute evidence directly to nurses' judgments about cognitive function, it played a significant role in influencing nurses to conduct the orientation assessment. The flowsheet was where nurses accounted for the work they did each shift and was a part of the patients' medical chart. Accountability has become a central focus in acute care as health care organizations and funders are under pressure to make practices more efficient

(Calnan et al., 2013; Daykin & Clarke, 2000; Rudge, 2011) and to protect the interests of the organizations (Kjorven, Rush, & Hole, 2011). The flowsheet was highly structured, and there was only room for tick marks related to cognitive function, indicating the patients' level of orientation. Because of this highly structured accounting system, nurses were not able to record their complex understandings of patients' cognition. Furthermore, the impoverished nature of this documentation system, where entries were regulated and often limited to tick marks, meant that it was not regularly used as a source of evidence about older patients' cognitive function. The flowsheet did however obligate nurses to record information about patients' cognitive function in the form of the orientation assessment specifically. The flowsheet therefore perpetuated the use of the orientation assessment as a method of constructing evidence about cognitive function.

Nurses' "cheat sheets" enabled them to carry important information about patients with them during their shift; however, these documents and the valuable information they contained were not shared with others. Cheat sheets were nurses' individual methods of recordkeeping; each nurse had their own system for recording patient information and logging emerging outcomes of interventions and assessments. In their qualitative study, Hardey, Payne and Coleman (2000) refer to similar documents used by nurses as "scraps". These authors describe scraps as a place for nurses to record their knowledge that was not constrained like other documentation systems. Furthermore, they note that such documents were actively used by nurses throughout their shift, and describe them as dynamic, in contrast to other forms of documentation that were static and only amended when time allowed. Similarly, I found that nurses relied heavily on their cheat sheets throughout their shift. While the cheat sheet was a valuable way for nurses to gain access

to important information that helped them construct evidence about patients' cognitive function, these sheets were not shared and therefore did not directly contribute to other nurses' understandings of the patient.

These four documentation systems contributed to nurses' judgments about the cognitive function of older people through structuring their practice related to cognitive function: the patient summary and report sheet served to communicate information about patients' cognitive function among nurses each shift, the flowsheet indicated to nurses that they needed to determine the patients' orientation and the cheat sheet was a source of patient information during interactions. Nurses' use of multiple documentation systems, however, also exemplifies how power was enacted in acute care. This study supports other scholars' contentions that documentation systems are not neutral structures, but serve to constrain and coordinate nurses' work (Berg, 1999; Cheek, 2004; Liaschenko, 1994; Peter, 2002; Poland et al., 2005; Moser, 2010). An implication of having multiple documentation systems is that nurses recorded their actions and judgments several times. Furthermore, these multiple systems meant nurses had to transcribe information from one documentation system to another in order for valuable information to be available to them and others when it was needed. These complex, time-consuming processes signify how power is enacted through the allocation of valuable resources (Poland et al., 2005). Nurses contributed the valued resource of their time (Dahlke & Phinney, 2008), by transcribing information multiple times to ensure the smooth running of the hospital, which not only included nurses having ready access to information but also ensuring access to other health care professionals and protection of hospital interests. Nurses' obligations to report and account for their work through documentation contributed to

what Malone (2003) calls “distal” nursing, work that takes place away from interactions with patients where nurses construct important evidence toward their complex practical judgments about patients’ cognitive function.

The invisibility of nursing knowledge. The way nurses constructed knowledge for themselves and other nurses, which contributed to their highly nuanced understanding of patients and their cognitive function, and served as a foundation for their actions, remained largely absent from documentation systems, and seemed to hold little value in the hospital. These findings contribute to a body of nursing literature that illustrates how the knowledge nurses use in practice is often discounted in health care settings (Cheek, 2004; Kjørven et al., 2011; Liaschenko, 1994; Malone, 2003). The documentation systems nurses used, as observed in this study, contributed to the invisibility of their complex knowledge of patients’ cognitive function. Bjornsdottir (1998) described two parallel discourses in acute care nursing, one private for those within nursing, and one public and accessible to others outside the discipline. This study supports the assertion that what was recorded and accessible to others in acute care was not the complete picture of nurses’ judgments about cognitive function. Nurses used a wide variety of evidence in their deliberations about older patients’ cognitive function; however, they only recorded particular kinds of evidence in documentation. The documentation systems nurses used in this study were highly structured, not only by sectioning and partitioning of the documents themselves, but also by the rules and norms that guided nurses’ contributions. What nurses’ recorded was constrained by such structures, contributing to the invisibility of the knowledge they used in complex practical judgments about the cognitive function of their older patients.

Nurses adapted their understandings about patients' cognitive function in order to fit the documents, and they left out knowledge that contributed to their judgments but did not conform to ideals of traditional scientific evidence. For example, nurses did not record interactions with family members or indications of patients' spiritual beliefs that contributed to judgments about their cognitive function. In a discourse analysis by Heartfield (1996), documentation in acute care was noted as having a conspicuous lack of patient and family voices. The author states that documentation uses "objective language that filters subjective information or shared understanding of the hospital experience of the patient" (Heartfield, 1996, p. 100). This study also found that even though knowledge constructed through interactions with patients and family was important to nurses' judgments about cognitive function, it was omitted from documentation systems, and remained hidden from others in the hospital.

The documentation systems used by nurses in this study were places to record traditional scientific evidence, and discounted other evidence nurses used in their judgments about cognitive function. Scholars such as Berg (1999) and Rudge (2011) argue that documents contribute to limiting communication in health care through relations of power that reinforce what is considered valid knowledge in documentation. The findings from this study demonstrate that the obligatory documentation systems used by nurses espoused values of efficiency and technical-rational reasoning, which contributed to how nurses' perceived the validity of their knowledge. For example, documents were compartmentalized by body system, and were completed through documenting objective, measurable evidence, while information important to nurses was condensed into code words and carried with nurses on their cheat sheets. Documentation

systems, and the social relations surrounding their use, limited nurses' agency to decide what knowledge was relevant to their judgments and what evidence ought to be passed on to others. Through contributing only limited kinds of knowledge to documentation, nurses were perpetuating the dominance of technical and instrumental discourses in the hospital while keeping the complex knowledge used in practice invisible, both to other nurses and to those outside of nursing. Nurses did however use verbal communication as a means to share complex knowledge that did not conform to traditional scientific ideals. Malone (2003) notes that nursing has a strong tradition of oral story telling due to a history of systematic exclusion of nursing knowledge from formal documentation systems in hospitals. This study seemed to confirm that observation.

Scientific evidence and accountability dominated documentation systems used by nurses in this study, which contributed to the invisibility of sophisticated nursing knowledge. Several nursing scholars have noted the void that is created by such documentation systems and specifically note how the complexity of nurses' knowledge is absent. Rudge, for example, notes that, "what rightly matters in the development of in-depth nursing knowledge gets hidden behind a mist of validation to come from counting nurses' work" (2011, p. 171). Furthermore, this absence of nurses' complex knowledge in documentation corresponds to distancing the patient from nursing care. Malone argues that the focus on accountability in nurses' work, and particularly the use of standardized documents, serves to "trivialize or ignore the profound contingency within any human interaction, contingency that permits the other to emerge in all his or her particularity, soliciting our moral responsibility" (2003, p. 2322). The current study demonstrates that nurses develop a complex understanding of patients' cognitive function, in large part

through their interactions with patients. However, the documentation systems they use are impoverished and contribute to the invisibility of nurses' intricate understanding of patients' cognitive function.

The role of nurses in acute care for older people. The findings have demonstrated that nurses' complex judgments about the cognitive function of older patients are undervalued in the hospital, and such undervaluing has had implications for nurses' role in hospital. I have shown that nurses have a complex process of understanding patients' cognitive function that enables them to do what is best for patients, and that is reflective of patients' particular situations; however, this process is largely undervalued in the hospital. The undervaluing of nurses' work in this study could be seen in how nurses understood their role in the hospital.

The findings demonstrated that nurses' roles had been diminished in a number of ways, which had implications for how they saw their role judging the cognitive function of older patients. Nurses' role in caring for older patients had been pared down, both by the increased presence of less educated care staff performing what is sometimes considered basic care work, and through more complex elements of their practice being allocated to other health care professionals. The nurses in this study minimized elements of their own work by suggesting that unregulated care staff, namely PCAs, could be responsible for what was considered basic care work, such as feeding, bathing and toileting. Physical care and intimate acts such as these elements of nurses' work, have traditionally been considered of lesser value than more intellectual tasks, such as planning, and have been allocated to less educated care staff (Cheek, 2004; Kjørven et al., 2011; Malone, 2003). In this study I found that nurses had, at least to some extent,

accommodated this practice, and even welcomed it at times. This finding suggests that the social relations surrounding the role of less educated care workers had contributed to nurses' perceptions of their role and the value of their knowledge. Furthermore, the nurses in this study suggested that elements of complex planning and assessment work related to the care of older people was outside of their role. They described what were considered advanced cognitive assessments, those achieved through the use of cognitive assessment tools, as outside general duty nurses' responsibility. They perceived such assessments as in the purview of other health care professionals, such as doctors, occupational therapists and specialized nurses. Moreover, the nurses suggested that they were not expected to be involved in discharge planning. The findings demonstrate what has been called "deskilling" by other scholars, a term they use to refer to the removal of complex skills and responsibilities from nurses' role (Calnan et al., 2013; Daykin & Clarke, 2000). This study shows how nurses' perceptions of their work also accommodate to these larger administrative and structural influences, and contribute to further dismissing their more sophisticated judgments and inhibiting them from working to their full capacity.

The findings from this study show that the nursing role was oriented toward ensuring the safety and physiological stability of patients. However, while their complex understanding of cognitive function was often invisible, they were expected to protect the interests of the hospital. There was an emphasis on the surveillance and control of older people, particularly those with cognitive impairments, in hospital, a finding echoed by other scholars (Cheek, 2004; Kjørven et al., 2011; Schofield, Tolson, & Fleming, 2012). Liaschenko's differentiation between surveillance and observation is important here:

observation is a method of attending to patients, while surveillance is concerned with being vigilant with the intent to control (1994). Nurses in this study demonstrated that their role included elements of both observation and surveillance. They observed patients in order to learn more about their cognitive function and to develop a complex understanding of the person's particular situation. Their observations included learning about how the patients' cognitive function would play a role in their safety and physiological stability, such as whether they would remember to use a call bell. However the nurse's role also included surveillance of patients and efforts to control their behaviours, particularly when safety was a concern. For example, nurses were expected to recognize when patients were demonstrating behaviours that indicated a risk of violence, and to initiate a Violence Alert in such cases. Schofield and colleagues (2012) also noted elements of both observation and surveillance in how nurses understood their role in caring for older patients with delirium in acute care.

This study contributes to the body of literature concerned with nursing staff mix and supports arguments that RNs play a pivotal role in assessing and planning patients' care through diverse and continual interactions with patients (Daykin & Clarke, 2000; Malone, 2003). Staff mix refers to the number and assortment of hospital staff providing direct care to patients (Canadian Nurses Association, 2012), and in this context, includes Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Patient Care Aides (PCAs). This study has demonstrated the invisibility of the complex judgments nurses make about the cognitive function of older people and how nurses themselves devalue aspects of their work that are traditionally considered less complex. The RNs in this study rarely spoke about their unique role, particularly when they compared their role to that of

LPNs, but also regarding the role of PCAs in performing what they considered routine care tasks. However, there are important differences between the education and training undertaken by RNs and LPNs or PCAs that have implications for how members of each group come to understand patients' cognitive function, and subsequently, how they enact care (Canadian Nurses Association, 2012). The findings from this study have significance for how care is allocated among care staff, particularly for patients who have complex cognitive conditions and would benefit from the most knowledgeable practitioners who can make critical decisions regarding their care. This study supports findings from scholars such as Malone (2003) who have demonstrated how planning activities cannot be separated from care work because nurses learn about what is best for patients' particular situations through interactions. Furthermore, scholars have noted how the transfer of care tasks from RNs to less educated care providers may mean that RNs do not have the same opportunities to interact with patients (Calnan et al., 2013; Cheek, 2004; Malone, 2003). This study has articulated the complex work of nurses in relation to how they understand the cognitive function of older patients through interactions, and can support nurses' unique contribution to caring for older people in hospital.

Summary

In this chapter, I have discussed the findings of this research in relation to current scholarship related to cognitive function and the nursing care of older people in hospital. The findings demonstrate the complexity of nurses' understanding of older patients' cognitive function and how the understanding is based on a range of evidence. Documentation systems are integral to organizing nurses' judgments about cognitive function; they contained evidence about cognition and coordinated judgments about

cognition. Nurses' complex knowledge is often invisible in the hospital, and this invisibility was perpetuated by values of efficiency and technical-rationality dominant in documentation systems. Furthermore, nurses' knowledge about patients' complex cognitive function is undervalued, which has implications for their role in hospital, including the narrowing of their responsibilities and unclear boundaries between the roles of RNs, LPNs and PCAs.

Chapter 10: Conclusions

The care of older people is, and will continue to be, a crucial matter for nurses in acute care. Cognitive function is a particular concern for those caring for older patients in acute care because it influences older patients' experience in the hospital and can affect the outcomes of their hospitalization. Nurses' understandings of patients' cognitive function contribute to how nurses determine their actions, but there has been little work done to articulate how nurses come to understandings about the cognitive function of older patients and how those understandings relate to their actions in practice. This study sought to address this gap by examining nurses' practice judging the cognitive function of older people in acute care.

A focused ethnographic approach was undertaken to explore a particular aspect of the culture of acute care nursing: how nurses understand the cognitive function of older patients. The methods used to collect data, including interviews, observation and document analysis, allowed an examination of the place of acute care, including the social relations that structured nurses' judgments about cognition. Twenty-one nurses from two units in a large acute care hospital participated in the study.

The findings demonstrate the complexity of nurses' judgments about the cognitive function of older patients, and how those judgments are situated in the place of acute care. In the first chapter detailing the findings, I began by describing the context of acute care for older people. This included a description of the nurses and other hospital staff, as well as the roles, space and routines of the acute care setting in relation to nurses' practice judging cognitive function. I also identified two goals of acute care nursing that had a significant impact on the way nurses understood cognition: ensuring safety and

securing physiological stability. This first chapter was a foundation for the ensuing chapters that explored in more depth the practical judgments nurses made about cognitive function and the context in which such judgments occurred. These chapters were organized based on three interconnected levels of social organization of nurses' practice: situated interactions between nurses and patients as well as their families, nurses' membership in a practice discipline, and the way obligations to the hospital structured nurses' work and hence their judgments of their patients' cognitive function.

In Chapter 6, I examined how practical judgments were socially organized through interactions with patients and their families. Interactions were an opportunity for nurses to make practical judgments through interactions with patients and their families. During these interactions, nurses gauged patient responses to determine if they fit with nurses' expectations of what were regarded as typical interactions for the particular patient, in their particular circumstances. Nurses' understanding of normalcy was constructed through knowledge of the patient's particular situation and nurses' socially situated understandings of what constitutes normal cognition. Interactions also served as an opportunity to determine how patients would "cooperate," a term used to identify patients' ability to follow the direction of nurses and other hospital staff.

In Chapter 7, I explored the place of nurses as members of a practice discipline in acute care to examine nurses' understanding of their role and how that role was organized through social relations in hospital. I further examined the documentation systems nurses used to communicate and report aspects of their work. Nurses' membership in this social group affected how they shared particular kinds of information with each other. They shared information about patients, including knowledge of their cognitive function as well as information about their specific physiological condition and the plan for their

care. Nurses used this information to develop a reference point for understanding their patients' cognitive function before engaging with them at the beginning of their shift, and could then "test" this tentative judgment through interactions over time, which then in turn further shaped their practical judgment.

In Chapter 8, the final findings chapter, I examined nurses' obligations to the hospital and how these obligations structured their judgments about the cognitive function of older patients. The function of the orientation assessment was discussed along with how power is enacted through documentation systems. The orientation assessment was valued in acute care and was used by nurses to validate their more tacit understandings of cognitive function gained through interaction. Nurses also tinkered with the orientation assessment, modifying the questions and interpreting answers toward a complex understanding of cognitive function. Although completing the hospital documentation related to cognition was important, at times nurses did not perform the orientation assessment, which further reflected how the patient's particular situation influenced nurses' understanding of cognitive function. In this chapter, I also discussed points of conflict for nurses, including the use of the Violence Alert and multiple reporting, and how these points of conflict demonstrate relations of power, and hamper the visibility of nurses' complex knowledge in the hospital.

These findings contribute to current gerontological nursing scholarship by demonstrating the complexity of nurses' knowledge about older patients cognitive function, how documents structure nurses' judgments and how nurses' knowledge is often invisible and undervalued in the hospital.

The methods used in this focused ethnographic study enabled a rich, in-depth examination of the place of acute care nursing around their judgments about the cognitive

function of older patients. This situated inquiry allowed an examination of the social relations contributing to nurses' perceptions of their role, and what they meant for nurses' practical judgments about cognitive function. Furthermore, the methods enabled an examination of relations of power and how they structured practical judgments about cognitive function, and contributed both to constraining and empowering nurses' particular actions.

Limitations

This analysis of nurses' judgments about the cognitive function of older patients is intended as a contribution to gerontological nursing knowledge that serves to support further knowledge development around how the cognitive function of people is understood in hospital; it does not claim to be an absolute or definitive account of nursing practice. Ultimately, it is an interpretation of the complexities of judging cognitive function in acute care, which will contribute to the current understanding of gerontological nursing practice in acute care.

A limitation of this study is that there were some nurses I could not access. They were the people who were unwilling to volunteer for the study. There may be a subset of those who did not want to participate that would have offered a different perspective than those who did volunteer. It is likely that those who volunteered for the study were more comfortable with the research process, and with having their work open to observation. Of the nurses who were approached to participate in the study (25), only four refused. Those who refused all attributed their refusal to concerns about their workload and perceptions that it would hinder their ability to accommodate a researcher. It is possible that those who did not volunteer had different experiences in the hospital.

Another limitation was that this study was conducted in one hospital. Given the complex nature of the social relations inherent in a place, it would be expected that the practice of nurses at other health care institutions might differ, for example, in the types of documentation systems used and the specific roles of general duty nurses. The findings could well have been different if conducted in another hospital, city or province. While the results of this study are not generalizable as such, they can be thoughtfully used to better understand nursing practice related to judging cognitive function in similar settings providing care to older people.

Significance

Notwithstanding these limitations, this research is a significant contribution to gerontological nursing scholarship. Through this research, I have shown that nurses make complex practical judgments about older patients' cognitive function in acute care, and that activities such as feeding, medication administration and mobilization, which are often characterized as "basic" nursing work, necessitate this kind of complex understanding of patients' cognitive function. This study provides support for nursing scholars who argue that nurses use a variety of evidence to determine their actions in practice. I have shown how social relations contribute to coordinating nurses' judgments about cognitive function, including documentation systems and the social norms and values associated their use. However, I have also shown how nurses' complex judgments about cognitive function of older people are often rendered invisible by such social relations, and how relations of power that prioritize traditional views of scientific evidence perpetuate the invisibility of nurses' complex judgments. This articulation of how nurses judge older patients' cognitive function is an important contribution to understanding nursing care of older people in hospital and serves to advance the current

discourse on how nurses' understanding of patients' cognitive function is reflected in their practice.

This study has demonstrated the complexity of nurses' judgments about cognitive function and how social relations in the hospital contribute to organizing such judgments. It underscores how nurses' role in hospital is unique and has shown how they provide an important perspective on the particular situation of older people and their cognitive function. However, the nurses in the study did not recognize the value of such complex judgments about cognitive function for the care of older people in hospital. Nurses' failure to ensure that their knowledge about patients' particular situations and experiences is visible in the hospital contributes to the undervaluing of their work and the silencing of the voices of patients and their family.

Through this study, nurses' goals of ensuring the safety of older patients, family and hospital staff, and securing patients' physiological stability were found to be particularly important. There remain however, important questions about whether these goals are indeed where nurses' efforts ought to be focused. These questions need to be considered not only by general duty nurses themselves but also by the wider nursing community, policy makers and those outside of the nursing and health care community who care about the health and care of older people in hospital. Other potential ends of the nursing care of older people have been put forward. For example, person-centered care has been described as a particular perspective that highlights the perspective of older people and the particulars of their situation including their life outside the hospital and the context of their care (McCormack & McCance, 2006). Such perspectives may better capitalize on nurses' expertise in understanding the complexity of patients' cognitive function. Conversations about what nurses' role in hospital ought to be are vitally

important, and to move practice forward in this way, there is significant work needed to uncover and make explicit how social relations could help support positive change.

Implications and Recommendations

The findings from this study have implications for nursing in the areas of research, policy, education and practice. In the following section, I will discuss these implications and offer recommendations based on the findings.

This study has demonstrated that the place of acute care, including social relations and relations of power, contributes to how nurses judge the cognitive function of older people. This finding shows the importance of considering the context of nurses' practice when examining the way they understand older patients' cognitive function, including the use of cognitive assessment tools in nurses' practice. As argued in Chapter 3, the nursing and health care literature has neglected to account for the context of nurses' work and this has contributed to a view that nurses are "under recognizing" cognitive impairments. This study supports contentions that nurses' understandings of patients' cognitive function are situated in complex social relations, including documentation systems and values related to safety and physiological health. More needs to be done to understand these social relations and how they play a role in how nurses construct evidence through cognitive assessments and use such evidence in practical judgments. Specifically, interventions that seek to implement cognitive assessment tools in nurses' practice need to include an examination of the context of the interventions. Poland and colleagues argue that an analysis of place can support practitioners in creating and implementing interventions that will be successful; "interventions wither or thrive based on complex interactions between key personalities, circumstances and coincidences" (Poland, Lehou, Holmes, &

Andrews, 2005, p. 171). The context of nurses' practice has implications for how cognitive assessment tools are taken up in practice.

Furthermore, there is a need to explore options for developing documentation systems that more accurately reflect the complexity of nurses' practice, including the knowledge they use in practice and their needs for communicating with other nurses. The social relations of the hospital, and specifically the documentation systems nurses contribute to are perpetuating values around traditional views of reasoning and have served to constrain how nurses communicate the complex knowledge they use in practical judgements about cognitive function. Participatory Action Research (PAR) is one method that might be particularly useful toward this end because it enables researchers to work collaboratively with practitioners toward improving particular areas of practice (Kemmis & McTaggart, 2000). PAR can also support an approach to documentation development that reflects the realities of nurses' work through continual input, and evaluation in the context of nurses' work (Kemmis & McTaggart, 2000). This study suggests that some changes that might be relevant are larger areas for freeform narrative (Berg, 1999), or one document for communication with other nurses that can also serve as the formal record. However, the specifics of such changes would need to be refined and examined for their relevance and ability to support nursing practice.

There are also important implications for nurse leaders and decision-makers in acute care settings. There is work to be done to determine who is responsible for documentation systems, and to hold them accountable for decisions about their structure. Documentation systems have a valuable role in acute care, but it is also important that they are not taken up uncritically (Berg, 1999; Poland et al., 2005). The place of documentation systems in acute care needs to be continually examined to determine how

they contribute to the social organization of nursing practice and to restructuring nurses' practice of judging cognitive function. General duty nurses who use the documentation systems need to contribute to determining their format, so that they better fit nurses' needs and role in the hospital. Such input could potentially lead to changes that decrease the burden of multiple reporting and led to documentation systems that are more inclusive of diverse types of evidence, including better assessment tools.

This study has demonstrated that documentation systems organize how nurses construct evidence about the cognitive function of older people, and specifically, how the flowsheet contributed to the use of the orientation assessment. The orientation assessment has been criticized in the literature as insufficient to determine cognitive function (Mezey, Fulmer, & Abraham, 2003; Palmateer & McCartney, 1985; Souder & O'Sullivan, 2000), yet it is still required on documentation in this setting and seems to serve a function. There are other tools that have better support in the literature as methods to gather objective, standardized evidence about cognitive function, such as the Confusion Assessment Method (CAM) (Inouye, Alessi, Balkin, Siegal, & Horwitz, 1990), which may be more appropriate for the flowsheet. However, given the apparent utility of the orientation assessment to nurses' practice, and the limitations of tools such as the CAM (for example, its limited use as a tool for understanding cognitive conditions other than delirium [Wei, Fearing, Sternberg, & Inouye, 2008]), it remains unclear which tool is best suited for nurses' seeking to understand the cognitive function of older patients in acute care settings.

The findings of this study also demonstrate how documentation systems contributed to the workload of nurses. Nurses in this study documented their understanding of patients' cognitive function on multiple documentation systems, and

had to maintain current and accurate information on the patient summary. Although necessary to ensure the smooth running of the hospital, these activities were time consuming and occupied nurses' valuable time (Dahlke & Phinney, 2008). Malone (2003) suggests that such activities can contribute to nurses becoming more distal to patients, meaning spending more time away from patients, rather than interacting with them. The findings contribute to the body of literature that argues nurses learn about patients through multiple interactions over time (Cheek, 2004; Benner, Tanner and Chesla, 2009; Malone, 2003; Moser, 2010). A recommendation from this study, therefore, is for policy makers to review the institutional expectations for nurses' reporting, and examine how such expectations affect nurses' interactions with patients.

This study also supports recommendations for nursing education. Primarily, the study highlights the need for more nuanced education about the complexity of nursing judgments about cognitive function. The study demonstrates that an array of knowledge was needed to develop the complex judgments about cognitive function that enabled nurses to provide care to older people. The evidence needed to develop such complex judgments often came from nurses' interactions with patients while performing what is sometimes understood as basic nursing, such as feeding, taking vitals signs and bathing. Nurses, however, devalued this aspect of their work by suggesting it could be done by unregulated and less educated care staff. Early education is needed to support nurses' recognition of the value of these important aspects of their work, potentially empowering them to make their complex practical judgments based on highly nuanced knowledge more visible in their practice environments.

Nursing literature on understanding cognitive function tends to focus on the construction of evidence through the use of cognitive assessment tools (e.g. Doerflinger,

2007; Greenberg, 2012; Registered Nurses Association of Ontario, 2010; Waszynski, 2001). However, the findings from this study showed that nurses did not use such tools in their practice. While not the only form of evidence nurses use in practical judgments, the use of standardized and validated tools is important in the health care context. Currently, there is no one tool that adequately constructs evidence relevant to every patient's cognitive function across situations, and that also supports nurses toward the goals of their practice. Ultimately, there may be a number of tools that nurses can draw on to support their practical judgments related to cognitive function. However, there is still work to do in nursing education to ensure nurses recognize the value of such tools in their practical judgments, and to foster empowerment among nurses to choose tools that reflect the needs of each particular patient.

While skills in using cognitive assessment tools are undoubtedly important, it is also important for nurse educators to demonstrate the role of other sources of evidence in judgments about cognitive function, such as interactions with patients, family input and the expertise of other health care professionals. This study demonstrates that nurses continue to value the perspective of health care professionals in the hospital over the experiences and perspective of older people and their family members. This was seen in how nurses valued patients' cooperation in the work deemed important by health care professionals, and in the uncertain role of families in acute care. Nurse educators can support nurses to include the voice of patients and their family members by explicitly demonstrating how such perspectives contribute to complex judgments about cognitive function as described through this study.

For nurses practicing in acute care with older people, this study is an articulation of one particular aspect of nursing work with older people in a specific hospital setting,

which can be used to support other articulations of practice. The findings demonstrate that nurses' complex knowledge is undervalued and often invisible in the acute care setting. Having a language to articulate the complexity of nurses' knowledge and judgments can support other nurses who are seeking a voice. For example, this study can support nurses who are involved in discussions about the staff mix of their work settings. The Canadian Nurses Association statement on staff mix recommends that nurses be part of discussions about staff mix; one of the guiding principles of the statement is: "Direct care nursing staff and nursing management are engaged in decision-making about the staff mix" (Canadian Nurses Association, 2012, p. 7). This study provides a language for nurses to articulate their complex contribution to the care of older people in hospital, particularly in understanding the complex cognitive function of older patients. Canam (2008) notes that nurses' language used in practice is particularly useful in articulating nurse' practice. The focused ethnographic methodology of this study allowed nurses' voices and actions to inform the findings and be reflected, in all their complexity, in the interpretations.

In conclusion, this focused ethnographic study has made significant contribution to the field of gerontological nursing, and has implications for nurses in research, policy, education and practice. The study has demonstrated the complexity of nurses' practical judgments about the cognitive function of older hospital people and shown how the social relations of acute care, such documentation systems, structure such judgments.

Furthermore, the social organization of nurses' work is exemplified in the perceived goals of nurses' practice—ensuring safety and securing physiological stability--and the ways that nurses experience conflict and enact power. This study has the potential to serve as a foundation for further examination of nurses' practice with older people in

hospital, and to act as an impetus for change in such environments, both of which can contribute to improving the nursing care of the growing number of older people in hospitals.

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Appendix A: Recruitment Poster



Volunteers Needed

Volunteers are needed for a nursing research study exploring how nurses understand cognitive function in older patients

We are looking for RN, LPN and Care Aide volunteers for a nursing research study. As a participant in this study, you would be asked to 'buddy' with a researcher for part of a shift (2-3 hours) **and/or** participate in an interview outside of work hours (1-1.5 hours).

For more information about this study, or to volunteer for this study, please contact:

Elaine Moody

Phone: [REDACTED]

Email: [REDACTED]

**Understanding how nurses judge cognitive function:
A description of acute care nursing practice with older people**

Version 1 – January 5, 2012

Appendix B: Observation Guidelines

Describe the physical environment of the unit

Nurses' Routine:

What tasks do nurses do?

When do they do what?

How do nurses record patient information?

When do they record the information?

Where do they record it?

What do they record?

When are breaks?

How many patients do nurses care for?

How do nurses respond to challenges in their work?

What makes their work easier?

Particular Situations:

Who works with who?

How do nurses interact with other hospital staff?

What do they say?

What types of information is shared?

How do nurses interact with older patients?

What do they say?

What do they do?

Where were the tensions in these situations?

Assessment Tools:

What types of assessment tools do nurses use?

How do nurses collect information for the tools?

How do they report the findings?

Appendix C: Interview Guidelines

If applicable, discuss the ‘buddy’ shift and particular occurrences during that time.

Examples of Previous Experiences:

Tell me about a time when you cared for a patient who was cognitively impaired?
How did you know?

Tell me about a time when you weren't sure if someone was cognitively impaired or not.
What made you think they might be cognitively impaired?
What made you think they might not be cognitively impaired?

Tell me about a time when someone’s cognitive function changed.
Why did you think their cognitive function had changed?
What did you see?
What did you hear?
What happened next?

Assessment Tools:

What type of cognitive assessment tools do you know about?
How is this tool used in your practice?
What information is collected?
How do you use assessment tools?
What makes using the tools easier?
What are the challenges using the tools?

Appendix D: Biographic Information



a place of mind
THE UNIVERSITY OF BRITISH COLUMBIA

Understanding how nurses judge cognitive function: A description of acute care nursing practice with older people

Biographic Information

First Language Spoken: _____

Age: _____

Gender: _____

Education Completed:

Type of Nurse: LPN
 Care Aide
(circle one) RN

Position: Full-time
(circle one) Part-time

How many years of nursing experience do you have? _____

How many years have you been in this hospital? _____

How many years have you been on this unit? _____

Participant Pseudonym: _____

Appendix E: Analytic Framework

DESCRIPTIONS

- What is the routine on the unit?
- Who are the major players (in nursing practice with older people in general and in understanding cognitive function specifically) and what are their roles?
- What is the role of different types of nurses (e.g. PCCs, RNs, Nurse Clinicians, Charge Nurses and LPNs) on the unit?
- How do nurses interact with others on the unit?
- What is the practice and role of the assignment?
- What language is used to talk about older people and cognition?
- How is technology used? Computer programs?
- What does safety mean to the nurses?
- Stories of delirium, dementia, post-op delirium, 'odd' people

NURSE/OLDER PATIENT INTERACTION

- How do nurses and older people interact?
- What brings on interactions?

NURSING PRACTICE

- What are the priorities of nursing practice (and how do you know)?
- What makes a good nurse?

UNDERSTANDING COGNITIVE FUNCTION

- What kinds of evidence do nurses use to come to understandings about cognitive function?
- How are the types of evidence used?
- What is important to nurses when someone is confused?
- What makes understanding cognitive function difficult?
- Is coming to an understanding about cognition a judgment?

FORMAL ASSESSMENT

- What formal cognitive assessments are done?
- How is information from these assessments used to come to understandings?
- When do they do these formal assessments?
- What challenges come with these assessments?

INFORMAL ASSESSMENT

- What subjective cues are nurses attuned to?
- What is the role of medications in understanding cognitive function?

RELATIONS OF POWER

- Where is there conflict in nurses' work?
- What makes their work difficult? (What distracts them?)
- How do these areas of tension impact nurses' work with older people?
- What motivates nurses in their practice?

ARTIFACTS

- What do the documents used by nurses ask about cognitive function?
- What do nurses record about cognitive function (language)?

AGING

- What are some assumptions that nurses have about older people?
- What is the importance and meaning of the age of the patient?



Appendix F: Consent Form for Hospital Staff

CONSENT FORM Hospital Staff

Understanding how nurses judge cognitive function: A description of acute care nursing practice with older people

Principal Investigator:

Alison Phinney, PhD, RN
Associate Professor
UBC School of Nursing
[REDACTED]

Co-Investigator:

Elaine Moody, PhD(c), RN
Graduate Student
UBC School of Nursing
[REDACTED]

Co-Investigator

Geertje Boschma, PhD, RN
Associate Professor
UBC School of Nursing

Co-Investigator

Jennifer Baumbusch, PhD, RN
Assistant Professor
UBC School of Nursing

This research is being conducted as part of a doctoral degree program and will be presented in a publicly available thesis. The research is partially funded by the Canadian Institutes of Health Research.

Purpose: This study is being done to learn more about how nurses work with older people in hospital and more specifically, how nurses assess the cognitive function of their patients. We are interested in how nurses use formal assessments as well as how nurses and patients interact in normal hospital care. You are being asked to participate in this study because you are employed by the hospital and you work with older people.

Study Procedures: If you agree to participate in this research you will be asked to:

- a) 'Buddy' with researcher for part of a shift
- AND/OR**
- b) Be interviewed by a researcher

If you agree to 'buddy' with the researcher, you will have a researcher with you for approximately 2-3 hours of your time with older patients during one shift. During this time the researcher will accompany you as you care for older patients and have conversations with other health care professionals.

If you agree to an interview you will meet with the researcher in a location and at a time of your choosing. You will be asked about your experiences working with older people and how you assess and determine their cognitive function. The interview will take approximately 1 to 1.5 hours and will be audio recorded.

Potential Risks and Benefits: There are no known risks involved with participating in this study. You will not receive any monetary compensation for your participation in this study.

Confidentiality: Your identity will be kept strictly confidential. During our observation, the researcher will make notes about your interactions with patients. Interviews will be audio recorded and transcribed. The findings will be reported back to the staff on your unit. As there will only be a small number of participants, it may still be possible for your colleagues to identify you. We will do all we can to prevent this from happening.

In order to keep your identity confidential, we will not use your real name in our notes and will remove identifying information from transcripts. No identifying information will be reported in the findings.

The data will be stored on a password-protected and encrypted computer only accessible to the researchers.

Information obtained in this study may also be used for educational purposes and for research involving secondary data analysis of the information that has been collected.

Contact information about the study:

If you have questions about this research please contact Elaine Moody at:

Email: [REDACTED]

Phone: [REDACTED]

Contact for concerns about the rights of research subjects:

If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604- 822-8598 or if long distance, e-mail to RSIL@ors.ubc.ca or toll free 1-877-822-8598.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your employment.

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.

Participant Signature

Date

Printed Name of the Participant

Appendix G: Consent Form for Patient or Family Member

CONSENT FORM
Patient or Family Member

**Understanding how nurses judge cognitive function:
A description of acute care nursing practice with older people**

Principal Investigator:

Alison Phinney, PhD, RN
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Jennifer Baumbusch, PhD, RN
Assistant Professor
UBC School of Nursing

This research is being conducted as part of a doctoral degree program and will be presented in a publicly available thesis. The research is partially funded by the Canadian Institutes of Health Research.

Purpose: This study is being done to learn more about how nurses work with older people in hospital and more specifically, how nurses assess the mental status of their patients. You are being asked to participate in this study because you are a patient in hospital who is assessed by nurses.

Study Procedures: The research involves observing nurses as they work with patients in the hospital. We would like to observe your nurses and how they interact with you during your normal care.

We are also interested in what the nurse writes in your chart about these assessments.

We are only interested in information about your assessments and function. We will not record any information that can identify you.

You can ask the researcher to leave at anytime or that anything you say be left out.

Potential Risks and Benefits: There are no known risks involved with participating in this study. You will not receive any monetary compensation for your participation in this study.

Confidentiality: Your identity will be kept strictly confidential. During our observation, we will make notes about your interactions with the nurse. In order to keep your identity confidential, we will not use your real name or other information that can identify you in our notes or in reporting the findings. The data will be stored on a password-protected and encrypted computer only accessible to the researchers.

Information obtained in this study may also be used for educational purposes and for research involving secondary data analysis of the information that has been collected.

Contact for information about the study:

If you have questions about this research please contact Elaine Moody at:

Email:

Phone:

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 RSIL@ors.ubc.ca or toll free 1-877-822-8598.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your access to further services from the hospital.

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.

Participant Signature

Date

Printed Name of the Participant

For family members signing on behalf of a patient: Please discuss this research with your family member who is a patient in the hospital.

I consent / I do not consent (circle one) to my family member's participation in this study.

Family Member Signature

Date

Printed Name of the Family Member