NURSES' PERCEPTIONS OF THE DIFFERENCE THEY MAKE IN THE LIVES OF PATIENTS AND FAMILIES

by

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ABSTRACT

Registered nurses are faced with the task of providing quality nursing care in environments where the workload has increased and resources have diminished. In order to maintain their role in caring for patients and families, it is important that nurses describe the essential services they provide in our health care system because those services are not well understood and often go unrecognized. Narrative inquiry methods were used in this study to gain information and understanding about how nursing practice makes a difference to patients and families. A sample of 12 registered nurses working in critical care areas of a large urban hospital in British Columbia volunteered to participate. Data was obtained through interviews that were audiotaped and transcribed verbatim. Nurses were asked to share stories about how their nursing practice made a difference to patients and families. Four narratives and one sub-narrative made up the findings. The narratives were as follows: 1) Making a difference every day; 2) Going the extra mile; 3) Putting myself in their shoes; and 4) Staying composed in hopeless situations. The sub-narrative was It’s not me, I’m part of a team.

In the first narrative, nurses’ stories were about providing competent routine nursing care ranging from life-saving events to the little things that nurses did that resulted in clear demonstrations of appreciation by patients and families. In the second narrative, nurses’ stories reflected how nurses made a difference to patients and families by doing everything in their power to make the hospital experience as positive as possible. In these stories nurses emphasized how they challenged norms, went against hospital policies, and sometimes confronted colleagues and other health care members to ensure patients and families received the care they needed. In the third narrative, nurses’ stories of making a difference involved imagining what it was like for their patients and families to be in the hospital. Nurses described how they used this strategy to anticipate what patients and families needed in planning their care. In the fourth narrative, nurses’ stories described situations where they provided support to
patients and families throughout the dying process by remaining realistic yet positive and always kind. Because nurses stayed composed they were able to focus on ensuring patient and family dignity throughout the grieving process. The sub-narrative revealed stories about how nurses were able to make a difference to patients and families by working as members of nursing teams and health care teams.

Findings from this research suggest that autonomous decision-making, along with increased levels of clinical expertise, and knowledge and commitment to work as a member of a team contributed to nurses' abilities to make a difference. The findings suggest important implications to nursing practice, nursing education, and future nursing research.
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Chapter One: Introduction

Background to the Problem

It is important that nurses describe what it is they do to make a difference to patients and families for a number of reasons. According to Benner (1984), experienced nurses must articulate what they do to benefit patients and families in order to educate other nurses. Descriptions of nursing practice enhance the understanding of other health care professionals about nursing roles and their ability to coordinate their work with nurses. Nurses that articulate the importance of their work can be more effective in influencing the public and the policy makers to ensure that factors essential to the provision of quality nursing care remain intact. And nurses themselves need to continue to share their success stories with their colleagues in order to increase individual self-esteem and improve the overall group image of the profession.

Health care reforms and increased demands for accountability increase the need for a better understanding of nurses’ work. Health care reforms have been underway for years in an attempt to improve health care delivery and cut costs but have accelerated substantially in the last few years. There is general recognition that the Canadian health care system is no longer sustainable. In order to manage growing deficits, there have been substantial cutbacks to funding for health care. The federal government has cut transfer fees to the provinces and the provincial governments have cut overall funding and specific funding for health care programs.

Registered nurses are faced with the task of providing quality nursing care in environments where the workload has increased and resources have diminished. As a result of health care cutbacks in some situations, registered nurses are being replaced with non-registered nurses. Research that supports that nursing care provided by registered nurses results in healthier outcomes for patients (Aiken, Havens, & Sloane, 2000; Aiken, Smith, & Lake, 1994; van
Servellen & Schultz, 1999) reinforces the need for registered nurses to explicate what it is they do and how they make a difference to the health of patients and families.

Over the last decade, a number of factors have developed that compel nurses to clearly articulate how valuable their work is in benefiting patients and families. Numerous nurses, nurse theorists, researchers, and health care professionals have attempted to describe nursing practice to the public but have been faced with a number of challenges. First, some antiquated beliefs held by the public suggesting that nurses are handmaidens to physicians remain today and block understanding of what nurses’ work actually entails. Second, much of nursing remains invisible, in part because nurses’ work involves caring for the human body, which in this society is considered private (Lawler, 1991). Third, nursing care is often provided to those experiencing pain and suffering. It has been suggested that the thought of learning about episodes of pain and suffering deters some people from wanting to understand nursing care (White, 1995). And lastly, despite the large numbers of nurses practicing in each of the provinces, nurses are just beginning to develop a united voice in describing what nursing practice is and what nurses require to provide quality care.

To achieve a fair, appropriate, and more effective health service for patients and families, nurses need to articulate their contribution to health care (Department of Health, as cited in Burton, 2000). Nurses’ work results in improved health, cost-savings to taxpayers, and a healthy society. Nurses, who make up the largest group of health care providers, direct their efforts through a wide range of interventions to prevent injury and promote health, manage acute illness and chronic disease, restore health, and provide home care and hospice assistance (Hegedus, 1999). To emphasize the importance of nurses, one needs only realize that the majority of the population will at one point in their lives require the expertise of a nurse (Picard, 2000).
Despite cutbacks and staff shortages, the majority of nurses strive to provide the quality nursing care the public has learned to expect (Radwin, 2000). Often under great time restraints, nurses work to provide patients with knowledge, skills, and assistance to maintain or improve their health. Their goal is to provide quality nursing care that benefits patients and families.

**The Problem and Purpose of the Study**

The essential services nurses provide in our health care system are not well understood and often go unrecognized. With budget cuts, staffing shortages, and organizational changes, nurses are challenged to continue to provide the nursing care required to benefit patients and families in less than optimal work environments. Despite evidence that high quality nursing care provided by registered nurses decreases mortality rates and increases patient satisfaction, there is little demand by the public to ensure nurses are able to carry out their work (Aiken, Havens, & Sloane, 2000).

A better understanding of nurses’ work obtained through detailed descriptions from nurses may help increase the visibility of nursing and help the public understand what nurses do and how their work impacts patients and families. This improved understanding will help inform hospital employers and policy makers of what nurses require in hospitals to provide quality nursing care. An added benefit of sharing nurses’ stories with each other is that nurses may experience enhanced feelings of self-esteem, an increased sense of belonging, and an improved sense of group cohesiveness within the profession. Sharing stories will help nurses make sense of events and help nurses see themselves more clearly. Stories that demonstrate how nurses make a difference may assist less experienced nurses in refining their practice, avoiding mistakes, and intervening with patients and families most effectively. Storytelling might also encourage other nurses to be courageous, since effective nursing requires nurses of courage.
The purpose of this study is to examine nurses' stories of the difference their nursing practice makes in the lives of patients and families. It is expected that the research findings will uncover subjective meanings, personal beliefs and attitudes related to nursing practice and its effects on patients and families.

**Definition of Terms**

The word “nurse” in this research study is defined as a registered nurse. “Nursing practice” refers to the work performed by registered nurses.

**Summary**

Research to examine nurses’ accounts of how their nursing care benefits patients and families is essential to help nurses articulate what they do and demonstrate the value of their work to the general public. This study will focus on nurses’ stories of what they do to make differences to the people they encounter.
Chapter Two: Literature Review

Introduction

This chapter presents a critical review of the literature related to nurses’ perceptions of their practice focusing on how nursing care benefits patients and families. In order to investigate these topics, the literature search concentrated on what nurses do, what is important about their work, how nurses’ work has been described, and how nursing practice influences patient outcomes. Anecdotal evidence will complement the research studies reviewed.

Initially, CINAHL (1966 to 2001) and the ERIC (1966 to 2001) databases were accessed in the literature search using keywords “nursing perceptions” and “perceptions of nursing practice” followed by “nurses’ attitudes,” “benefits of nursing practice,” “health professional perceptions,” “health care benefits,” and “benefits of health care.” The COCHRANE library was also accessed to review possible meta-analyses related to the research topic. No meta-analyses were found. The CINAHL and ERIC results were scarce with a total of 39 potentially relevant articles, the majority consisting of non-research based documents.

During the next phase of the search, all OVID, Silverplatter, and PubMed databases were accessed, including MEDLINE and PsychInfo using the same keywords. The publications retrieved in these searches focused mainly on public health nursing instead of hospital-based nursing. Nonetheless, new keywords were identified as trends in the literature were recognized. Additional keywords used in the search included “health promotion,” “nursing interventions,” and “nursing outcomes,” as well as “workplace trends,” “job satisfaction,” “nursing as an art and science,” and “caring in nursing.”

To review literature focusing on descriptions of nursing practice, the third phase
of the literature search focused on descriptions of the "essence of nursing" and the "invisibility of nursing". A number of books were accessed on nursing theories, caring, and the nature of nurses' work.

Finally, the phrase "professional identity" was used as a search term. I hoped to find research outlining characteristics that were important to nurses in identifying themselves as professionals and how professional identity was linked to making a difference to patients and families. A small number of pertinent research articles were recovered through a CINAHL search.

The literature search did not uncover a single research article solely describing hospital-based nurses' perceptions of the difference their nursing practice makes in the lives of patients and families. Few research articles addressed nurses' perceptions of the difference nursing makes at all and those that were found, focused on public health, home care, and long-term care nurses (Allan, 2001; Hegedus, 1999; Riccio, 2000). Evaluations of the magnet hospitals in the United States have linked nursing care to improvements in hospital outcomes including morbidity and mortality (Aiken, Smith, & Lake, 1994; van Servellen & Schultz, 1999). Descriptions of patients' perceptions of nursing care, including their satisfaction with nursing care provides some insights about how nursing practice might make a difference to patients and families (Evans, Martin, & Winslow, 1998; Hankela & Kiikkala, 1996; Hegedus, 1999; Leinonen, Leino-Kilpi, & Jouko, 1996; Mayer, 1987; Oermann & Templin, 2000; Radwin, 2000; Tolson, Smith, & Knight, 1999.) Researchers have also identified a number of factors influencing nurses' ability to provide effective care including nursing shortages, role confusion and definition, workplace changes, increased stress, patient demands for quality health care, and patient self-determination and control (Anders, 1999; Beyers, 2001; Biester, Duggan, Perkins,

The pertinent literature resulting from this search will be presented in four main sections. The four sections are as follows: the invisibility of nursing, how nurses’ work has been described, literary evidence of how nurses make a difference, and current health care trends and their effect on nursing practice.

Invisibility of Nursing

Noticeable in the literature are articles describing the invisibility of nursing (Anders, 1999; Barker, 2001; Beyers, 2001; Buresh & Gordon, 2000; Hancock, 1997; Lawler, 1991; Picard, 2000; Powell, 2001; White, 1995). These articles are not research based but instead, reflect a general perception by nurses that their work is often unrecognized. The authors propose a number of reasons for nurses’ invisibility. Some suggest that invisibility may be because nurses’ work involves the body, which in this culture, is considered private and in some cases dirty. Nurses protect patients from exposure and contribute to the invisibility of their work by maintaining patient privacy. Others suggest invisibility may arise from the fact that nursing practice is difficult to describe due to its complexity. It is difficult for lay people to understand what nurses do unless they actually receive nursing care. Finally, some propose that nursings’ invisibility arises from the perception that caring is a menial job and therefore undervalued, dedicated to women of whom the majority of nurses are (Lawler, 1991).
Picard (2000) states that the invisibility of nursing comes from an uninformed public that thinks that caring and compassion, characteristics of a good nurse, can be provided by almost anyone. White (1995) argues that nursing is invisible to the well and active because thinking and acknowledging nurses' work forces people to also acknowledge the context associated with the need for nursing care; that is, pain and suffering.

A growing number of nursing leaders have argued that nurses need to begin to share their stories about their work with the public and other nurses to address the problem of the invisibility of nurses' work. Buresh and Gordon (2000) emphasize the need for nurses to describe their work and educate the public by conveying the complexity of the care they provide and the clinical judgments they use. Nurses need to learn to accept acknowledgement for their work, to share their opinions concerning patient care and health care changes with other health care providers, and to share stories and anecdotes with the public. Roberts (2000) strongly believes that the time is ideal to tell the public about nurses' work. As the nursing shortage is being felt worldwide, public attention has been directed to the influence nurses have in the health care system. Ohlen and Segeston (1998) also suggest nurses share their experiences through narrative and reflection to strengthen their professional identity.

**How Nurses' Work has Been Described**

Different approaches have been used to describe nurses' work. The following topics will be addressed to illustrate how nurses' work has been described: nursing theories and models describing the essence of nursing, research on caring in nursing, quality nursing care, and measuring quality of care.
Nursing Theories and Models Describing the Essence of Nursing

A number of nursing theories and models to explicate the nature of nursing practice have been developed (Allen & Jensen, 1996; Chinn & Kramer, 1999; Kerr & MacPhail, 1996; Kim & Kollak, 1999; Moody, 1990; Morse, Bottorff, Neander, & Solberg, 1991; Morse, Solberg, Neander, Bottorff, & Johnson, 1990; Orem, 1991; Roy, 1984). Some nurse theorists have focused on developing grand theories to describe nursing practice and others have developed mid-range theories and conceptual frameworks to describe specific approaches for nursing care and the caring practices of nurses. Still others have focused on describing concepts and constructs used in nursing such as body image, resilience, and uncertainty. These theories, models, concepts, and constructs represent efforts to explicate the nature and scope of nursing practice. Through quantitative and qualitative research techniques, some researchers have tested and further developed nursing theorists' ideas (Kerr & MacPhail, 1996).

Descriptions of nursing work date back to Florence Nightingale and have formed the basis of much theorizing in nursing since that time. Researchers have contributed to this growing body of knowledge recognizing that nursing knowledge is different than that of other health professions. They have devoted energy to describing the elements of nursing, the benefits of nursing care, the determinants of health, behaviours of individuals and populations, and the effects of changing environments (Chinn & Kramer, 1999; Kerr & MacPhail, 1996).

A historical view of the development of modern nursing and nursing science reflects the evolving role of nurses from being subservient to the church and to physicians, to assuming autonomous roles. Important to the development of nursing has been the advancement of nursing as a profession. Despite ongoing debate about what defines a profession and whether nursing is a profession, nurse researchers have begun to develop a formal knowledge base for
nursing practice. Regulating bodies were created throughout Canada to improve standards of practice and education, to register members, to monitor professional conduct and to allow qualified nurses the title registered nurse. Advancements in education to include graduate programs enhanced further and ongoing development of scientific nursing knowledge. A code of ethics was developed that illustrated nursing’s professional commitment to the public (Kerr & MacPhail, 1996).

As nurses have moved from a subservient role to an autonomous role, nurse theorists have been encouraged to develop theories that move away from the disease/treatment medical orientation in an attempt to describe the unique characteristics of nursing (Farmer, 1996; Henderson, 1980). Throughout nursing history, all nurse theorists have attempted to describe the essence of nursing to some degree. Their theories stem from different conceptual and philosophical orientations. Key leaders that have influenced theory development include Peplau, who in 1952 argued that interpersonal relationships were the basis for nursing practice; Weidenbach, who in 1964 suggested clinical nursing was a “helping art”; and Henderson, Rogers, King, Orem, and Travelbee, each of whom published a number of books on nursing theories and concepts from 1966 to 1971. Henderson focused on the nature of nursing, arguing that nurses help patients perform activities that contribute to patient independence towards health, recovery, or a peaceful death. Rogers introduced the theoretical basis of nursing and described nursing as care provided to unitary human beings, defined as energy fields coexisting with the universe. King developed the interaction model, suggesting that patients need help and nurses offer help in order for patients to attain health. Orem developed the self-care deficit theory, arguing that patients benefit from nursing when they are limited in providing their own
Travelbee suggested that nursing is an interpersonal process where nurses help patients, families, or communities to prevent or cope with illness or injury (Chinn & Kramer, 1999). Additional leaders who have influenced nursing theory include Neuman, who in 1974 developed the health care systems model to guide nursing practice; Roy, who proposed that supporting adaptation was the essence of nursing practices in 1976; Leininger, whose conceptualization of nursing practice focused attention on the importance of transcultural caring in 1978; Watson, who in 1979 theorized that human caring was the essence of nursing; and, more recently, Benner, who in 1984 described the components of expert clinical nursing practice (Chinn & Kramer, 1999; Moody, 1990).

In an effort to describe what is important about what nurses do, authors have attempted to argue what is at the core of nursing. Descriptions of caring as the essence of nursing have received wide support (Drugge, 1991; Jillings, 1989; Kitson, 1999a, 1999b; Mantle, 1988). Morse, Bottorff, Neander, and Solberg (1991) provide a synopsis of the theories of caring. Through comparative analysis, they found that caring theories could be summarized into five perspectives: caring as a human trait, as a moral imperative, as an affect interaction, as an interpersonal intervention, or as a therapeutic intervention. The authors raise a number of issues that need clarification: is caring unique to nursing; does caring change with different patients; and can caring be measured and evaluated?

The development of nursing theories, models, concepts, and constructs has provided important insights about nursing practice and its unique characteristics. However, these descriptions of nursing are abstract and complex, making it difficult to use them with all audiences to explain nursing practices. There is also debate within nursing about the degree in
which these theories capture important aspects of nursing practice as it occurs in the wide range of practice settings nurses work.

**Caring Research in Nursing**

Research examining patients’ and nurses’ views of caring behaviours demonstrates the difficulty in defining what are the most important elements in providing nursing care (McKenna, 1993). Discrepancies between nurse perceptions of caring behaviours and patient perceptions of caring reveal that nurses place more importance on involvement and expressive caring behaviours, whereas patients place more emphasis on instrumental behaviours (Morse, Solberg, Neander, Bottorff, & Johnson, 1990). For example, Mayer’s (1987) and Hegedus’s (1999) research studies demonstrate the lack of consensus found between patients and nurses in ranking caring behaviours. In Mayer’s quantitative study, using the CARE-Q instrument, 28 oncology nurses and 54 cancer patients ranked 50 caring behaviours in order of importance. Nurses ranked expressive behaviours as most important while patients ranked instrumental, technical caring skills as most important. Hegedus found in her study of medical/surgical nurses and adult patients hospitalized for medical illness or minor surgery that patients placed more value on nursing behaviours that recognized their individual and family perspectives, anticipatory teaching, and preparation for change. Nurses, on the other hand, placed more value on behaviours aimed to comfort and encourage patient expression of feelings, and allow patients to vent frustrations. An important limitation of these studies is the use of predetermined and researcher-defined caring behaviours. It is possible that important caring practices from the perspectives of nurses or patients may not be fully captured. In addition, it is unclear which caring practices make the most difference in relation to desired patient outcomes.
It has been noted that nursing theories on caring are not entirely consistent with society's views of caring. Morse and her colleagues (1990) found that the five perspectives of caring developed by theorists might not all provide adequate guidelines for nursing practice. Caring is considered by some authors to be the basis for all nursing actions, yet society considers caring altruistic and does not value caring. As nurses face increasing constraints on time and resources that are needed to provide care, their ability to be caring is undermined. Further research is needed to provide insight into nurses' perceptions concerning their ability to "care" in ways that make a difference to patients and families in changing health care climates.

**Quality Nursing Care and Measuring Quality Care**

Disregard for what nurses need to work effectively in health care systems and to provide quality nursing care is a major problem facing nurses (Kitson, 1999b). In accordance with the present study, Kitson identifies the need for nurses to articulate what it is they do, how they benefit populations, and what they need to continue to provide quality patient care.

Research studies dating as early as 1987 were found that address the quality of nursing care. Since quality of nursing care is a very complex concept, researchers have struggled to describe it. Some researchers have focused on evaluating quality nursing care, others have assessed nurses' ability to measure quality care, and still others have described nurses' and patients' perspectives of quality nursing care (Biester, Duggan, Perkins, Powers, & Classick, 1999; Grindel, Peterson, Kinneman, & Turner, 1996; Hogston, 1995; Hyrkas & Paunonen-Ilmonen, 2001; Langemo, Anderson, & Volden, 2002; Leinonen, Leino-Kilpi, & Jouko, 1996; Mayer, 1987; Oermann & Templin, 2000; Radwin, 2000; Williams, 1998).

It is assumed that in order to make a difference to patients and families, nurses need to be able to provide quality care. Nurses' own evaluations of the quality of their care are important to
strengthen nursing as a profession. In one study focusing on nurses’ perceptions of quality nursing care, Williams (1998) interviewed 22 registered nurses employed in an acute-care public hospital. When nurses had sufficient time, they perceived their care to be therapeutically effective and were able to provide care that was exemplary and of high quality. When they had insufficient time, nurses perceived their care to be therapeutically ineffective and were able to provide only basic and low quality care. Nurses perceived the inability to provide quality care as stressful and, as a result, when this occurred they felt dissatisfied with their work.

Using a qualitative, grounded theory approach, Hogston (1995) found that nurses (n = 18) used objective methods such as evaluating patient care plans and subjective methods such as peer review and intuition to appraise quality nursing care. Hogston suggests there are dangers in nurses failing to review the quality of their own nursing care; that is, they risk having non-nurses measure quality using evaluation tools that do not adequately capture nursing care.

A number of research studies were uncovered in the literature search that attempted to explore factors that influence quality nursing care. Researchers Hykras and Paunonen-Ilmonen (2001), who conducted and analyzed group interviews with 62 nurses, reported that clinical supervision provided the nurses support, enabling them to provide quality nursing care. However, the researchers reiterate the debate surrounding quality of care by highlighting the variations in definitions of “quality nursing care”. Grindel, Peterson, Kinneman, and Turner (1996) found that ongoing assessment of the work environment is vital to ensure that patient outcomes and nurses’ job satisfaction remain positive. Using quantitative and qualitative techniques to assess the viability of a tool to evaluate the practice environment on a continuous basis, the researchers found that nurses who perceived themselves as more autonomous and who
collaborated with health care providers in their jobs, experienced greater job satisfaction. Increased job satisfaction associated with provision of quality nursing care.

Wootten’s (2000) qualitative study focused on nurses’ perceptions of the value of 12-hour shifts in improving the quality of nursing care. Results suggested that 12-hour shifts allowed nurses to pace their workloads more effectively but also resulted in increased feelings of fatigue during, after, and at the end of the shifts. In another qualitative study of nurses the importance of continuing professional education to enhancing the quality of nursing care was determined (Hogston, 1995). Lynn and Kelley’s (1997) prospective quasi-experimental study revealed that case management helped to increase the quality of nursing care by affording nurses improved relationships with patients, increased therapeutic interventions, improved institutional support, and increased control over practice. Clearly, more research is needed to examine the quality of nursing care and the proposed research may add to this body of knowledge.

Other researchers have attempted to describe quality nursing care from the point of view of patients. In a grounded theory study, Radwin (2000) interviewed 22 oncology patients who received nursing care. The findings suggest that when patients receive quality care they benefit by achieving a sense of well being and increased fortitude that enables them to get through cancer treatments. Patients achieved a sense of well being from the development of nurse-patient relationships that were based on trust, optimism, and authenticity. Increased fortitude was attained through relationships with nurses who were professional and knowledgeable, attentive and committed; who provided coordinated care, considered patients partners in their care, treated patients as individuals, and developed rapport. Radwin’s study emphasized that nurse attributes, such as professional knowledge, continuity, attentiveness, coordination, partnership, individualization, and rapport and caring, resulted in positive health care outcomes.
Patient outcomes from hospital stays have served as benchmarks to measure the quality of nursing care. Quality of nursing care is, however, more complex than just decreasing morbidity or mortality. It also involves nurses’ job satisfaction, nurse retention, patient satisfaction, patient-length-of-stay and health status, working conditions, and evidence-based practice (Aiken, Havens, & Sloan, 2000; Blegen, Goode, & Reed, 1998; Buchan, 1999; Freeman & O’Brien-Pallas, 1998; McNeese-Smith, 1999). Hodges, Icenhour, and Tate (1994) state that the most well known measurement of quality of care is the Donabedian (1966) framework that measures quality through structure, process, and outcome. Hodges and her colleagues reiterate that outcome measures have received greatest emphasis and reflect the improvement of the patient’s psychological, social, and physical health status that can be attributed to antecedent care. With increased articulation by nurses about what they do and how they make a difference to patients and families, improved techniques to measure the process of providing care may be attained (Martin, 1994).

Evidence of How Nurses Make a Difference

There is a small but growing body of research focusing on how nurses make a difference to patients and their families. Research articles consist of studies done on magnet hospitals; that is, those hospitals in the United States that attract nurses and have high retention rates. Studies concerning nurse sensitive “patient outcomes” also provide evidence regarding how registered nurses make a difference to patients. Researchers are demonstrating how important nurses’ work is in producing positive outcomes, decreasing health care costs, and lowering rates of mortality and morbidity. To review the literature concerning how nurses make a difference, a number of books will be addressed followed by discussion of the research on outcomes and the magnet hospital studies.
Benner's (1984) book, *From Novice to Expert*, describes her research on the development of nursing expertise and is one of the most influential studies in nursing in the last decade. Benner's book represents one of relatively few studies portraying nurses in their active role of making a difference to patients. The research involved interviews with 21 pairs of preceptors and newly graduated nurses, and 51 experienced nurses. Benner concluded that experience and practical knowledge allowed expert nurses to immediately understand and intervene in any nursing situation. She identified seven domains of nursing practice: the helping role, the teaching-coaching function, the diagnostic and patient-monitoring function, effective management of rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring the quality of health care practices, and organizational and work-role competencies. Benner suggested that much can be learned from expert nurses who record what they learn from their own nursing practice, explain what they do, and describe how their practice affects patients. These data can be invaluable in developing and extending nursing theory.

Lawler (1991) provides more insight into what nurses do and the importance of their work in a grounded theory study involving 29 registered nurses, 2 students, and 5 enrolled nurses. The study focused on how nurses manage caring for the body and how nurses' work is influenced by social attitudes concerning the body. Lawler identifies that the caring for the body is undervalued and taken for granted since women, of which the majority of nurses are, have been historically responsible for caring for the bodies of babies, children, and the infirm. Lawler aids in bringing out into the open discussion about nurses' work that surrounds the taboo subject of body care and the creativity and critical thinking that goes into caring for an individual. Some of the "invisible" aspects of nursing are revealed in this important work and demonstrate the
value of examining nurses’ descriptions of their everyday experiences to understand nursing practice.

Picard (2000) traveled across Canada to interview hundreds of nurses in order to learn what they do. He discovered that even during daunting circumstances, nurses provide vital health care interventions to patients and their families and help patients return to health. Picard’s (2000) book is an inspirational account of the difference nursing practice can make to patients and their families. Unfortunately, he does not describe the interview and interpretation methods used and therefore it is not possible to evaluate the credibility of the findings.

Buresh and Gordon (2000) in their book, From Silence to Voice, report from interviews with nurses working in many contexts, that the complexity of the care provided by nurses is reflected in the clinical judgments they make and their clinical reasoning supporting those judgments. Although the focus of their book is to discuss the invisibility of nursing and to suggest ways of increasing nurses’ visibility, Buresh and Gordon illustrate that ordinary nurses make profound differences to patients and their families through their nursing practice.

An exploratory descriptive qualitative study by Reutter and Ford (1997) of the 28 public health nurses in Alberta, Canada illustrates their experiences in making a difference to patients and families. Based on a grounded theory analysis of interviews with these nurses, the researchers reported that the nurses believed they made a difference through sharing expert knowledge. By detecting potential health needs and taking advantage of every opportunity to teach their patients about health, the nurses believed that they prevented future problems. Other interventions that the nurses saw as important in their ability to make a difference were giving positive feedback, being available when needed, and using gentle persuasion to increase compliance and improve health. The study is valuable since it describes how public health
nurses perceive that they make a difference through their work. These findings, however, may not be generalizable to nurses working in acute care settings.

More recently, Madjar and Walton's (2002) study provides an example of the insights that can be obtained through narrative research. The Australian study spanned a three-year period and focused on how nurses make a difference. Analysis of the stories of 46 nurses revealed accounts of heroism where nurses made a difference to patients by “stepping out of line”, risking criticism from colleagues, and working for the patient’s best interest. Since the study was conducted in Australia, similar research is necessary in other settings where responsibilities and working conditions may be different.

**Magnet Hospitals and Outcomes Research**

Magnet hospitals are those hospitals in the United States that have been identified as comprising certain characteristics that attract nurses and have high retention rates. Nursing staff are allowed a great deal of autonomy, have input in decision making, are encouraged to further their education, and are given opportunity for advancement. Nurses working in magnet hospitals have been observed to have high levels of job satisfaction and to work well in multidisciplinary teams (Aiken, Havens, & Sloane, 2000; Aiken, Smith, & Lake, 1994; Kramer & Schmalenberg, 1988a, 1988b). Most importantly, evidence indicates that patients do better when cared for by registered nurses in magnet hospitals. Their hospital stay is generally shorter, the readmission rates are lower, and the patients claim a high satisfaction level of nursing care (Blegen, Goode, & Reed, 1998). Additionally, research shows that higher ratios of registered nurses to other nursing personnel in magnet hospitals decrease patient mortality rates (Aiken, Smith, & Lake, 1994; Sochalski, Estabrooks, & Humphrey, 1999; van Servellen & Schultz, 1999).
Negative outcomes and events such as mortality rates, rates of readmission, infection, hospitalization-related complications, and patient dissatisfaction are often used to measure nursing care and health outcomes (Mahrenholz, 1999; Radwin, 2000; Radwin & Alster, 1999). Numerous studies have been conducted to assess patient-identified outcomes that may better reflect how nursing care makes a difference to patient health status (Evans, Martin, & Winslow, 1998; Hegedus, 1999; Mahrenholz, 1999; Radwin, 2000; Radwin & Alster, 1999; Riccio, 2000).

There has been difficulty in determining how to measure outcomes of nursing care and the literature reflects this difficulty (Brooten & Naylor, 1995; Reed, Blegen, & Goode, 1998). Although mortality and morbidity rates are often measured to understand the patient outcomes, mortality has been most often used as an indicator of medical care. And morbidity, such as infection rates and complications, are usually used as indicators of inpatient care of which nursing is a part. Efforts have been made to identify outcome measures that specifically reflect nursing care. Some categories may include physiological and psychological status, quality of life, functional status, symptom control, knowledge and behaviour, safety, caregiver burden, resolution of nursing problems, cost of care, and patient satisfaction (Brooten & Naylor, 1995). Brooten and Naylor identify the need to more fully publicize the evidence that nursing interventions do make a difference and the need to identify nurse-sensitive outcomes. They also point to the difficulty in determining nurse-sensitive outcomes in circumstances where nurses are part of a team of caregivers. Harris and Warren (1995) reiterate that outcome measures will only be useful if they are applicable, practical, comprehensive, reliable, valid, and responsive. Further study of nurses' descriptions of how they make a difference to the well being of the individuals and families they care for may provide direction for identifying nurse-sensitive outcomes.
Current Health Care Trends and Their Effect on Nursing Practice

Health care services have come under increasing pressure from governments as they try to manage the spiraling costs of health care and from the public who are demanding effective and timely health care. Provincial governments across Canada are instituting major changes to the way health care is delivered. Newspaper articles and newscasts reflect the ongoing dialogue and debate regarding how to reform health care. Descriptions of how nursing practice benefits patients and families are needed to ensure that health care reforms support the provision of quality nursing care (Ohlen & Segesten, 1998; Roberts, 2000).

Health care reforms have already begun to impact the way nursing care is delivered and the effects of the reforms will continue as health care agencies cope in a climate of economic restraint and continued change. Health care reform has resulted in decreased numbers of registered nursing staff, decreased job security, increased numbers of unlicensed assistant personnel, increased workload and work pace, and increased acuity of patients. These changes have significantly affected the way nurses do their jobs (Corey-Lisle, Tarzian, Cohen, & Trinkoff, 1999). A survey of 1,098 randomly selected registered nurses conducted as part of the Nurses’ Worklife and Health Study revealed that the stress caused by health care reform has decreased nurses’ morale, decreased work satisfaction, increased turnover rates, and may lead to changes to careers or professions. Nurses also reported some positive outcomes resulting from health care reform including increased nursing flexibility, increased education, and job promotions (Corey-Lisle, Tarzian, Cohen, & Trinkoff, 1999; Kerr & MacPhail, 1996).

A longitudinal study (Woodward, Shannon, Cunningham, McIntosh, Lendrum, Rosenbloom, & Brown, 1999) involving a random sample of hospital staff (n = 900) revealed that re-engineering and other cost reduction strategies at a hospital led to a significant decrease in
the perceived quality of patient care and a rise in stress levels. The perception of decreased quality of care and increased stress levels amplified as time passed and changes continued. Although the study sample included other professional groups in addition to nurses, the findings provide a sense of the impact of widespread change in health care organizations and point to the need for further study of the effects of health care reform.

A qualitative study provides additional evidence of the influence of organizational structures on nursing practices. Williams (1998) found that nurses employ different strategies to deliver quality nursing care depending on the amount of time available to carry out their work. She identified four phases of focusing: self focusing, needs focusing, patient focusing, and quality focusing. These phases were seen to balance the work satisfaction of nurses with the safety of patients. Self focusing was used by nurses under a lot of stress and acted as a measure of self-preservation. During this phase, low quality nursing care was delivered. Needs focusing was used when insufficient or minimal time was available. Basic nursing care was provided to meet prioritized patient needs. Patient safety guided nursing interventions and more emphasis was given to physical needs at the expense of psychosocial needs. Patient focusing was used when sufficient time was available. This type of focusing enabled nurses to manage their stress levels and increase their work satisfaction. Only certain patients were provided quality nursing care and others were provided basic to low quality patient care. The patients who received the most time enjoyed exceptional care that included physical and psychosocial interventions. Quality focusing occurred when ample time was available. Unsurprisingly, this type of focusing resulted in the highest level of nurse, patient, and family satisfaction. Quality focusing was defined as care provided to a patient by a team of health care workers. All the needs of the patient were met. Williams’ work provides further evidence that changes that influence the
structure of nurses' work hold significant implications for the quality of care that is provided. Given the extent and pace of current health care reforms, it is essential that research focus on how nurses are able to provide quality nursing care in this environment.

**Summary**

Despite nursing research efforts to define the unique contributions of nurses and describe quality nursing practice, we still lack a full understanding of nurses' accounts of how their nursing practice makes a difference to patients and families. Nursing scholars, doctors, professors, medical researchers, and lay people alike have described nurses' work in numerous ways, but little attention has been placed on nurses' views of their work. A better understanding of how nurses make a difference to patients and families is critical to ensure that continued health care reform preserves rather than undermines nurses' ability to provide quality nursing care.
Chapter Three: Methodology

Research Design

Research methods are used to acquire information and should be chosen accordingly to best answer or address a particular question or concern. As demonstrated in Chapter Two, there is relatively little information available concerning nurses' descriptions of the difference their nursing practice makes in the lives of patients and families, particularly in the context of work environments influenced by health reform. Furthermore, knowledge gained from such descriptions may hold important implications for policy and decision making related to nurses' work. As qualitative research is best suited when little is known about a particular experience or topic (Morse & Field, 1995), it was used for this study.

Qualitative research allows the researcher to take an inductive holistic view of a subject. While phenomenology, grounded theory, and ethnography are better known and more frequently used qualitative methods, narrative inquiry (also known as narrative research) is becoming more popular for researchers to employ in the social sciences (Lieblich, Tuval-Mashiach, & Zilber, 1998) and in particular, the health professions (McCance, McKenna, & Boore, 2001; Thorne, Joachim, Paterson, & Canam, 2002). This is evident by the increased number of studies done using narrative inquiry and the growing number of articles and books published on the topic (Mishler, 1995).

This project is a precursor to a larger study that will view nursing practice from the perspective of registered nurses (RNs), registered psychiatric nurses (RPNs), and licensed practical nurses (LPNs). For the purpose of this thesis, the researcher examined nursing practice from the perspectives of registered nurses working in critical care settings. This descriptive study made use of narrative inquiry methods (Clandinin & Connelly, 2000; Coffey & Atkinson,
The narrative inquiry research approach has been used for this study because it is suited to investigate real-life issues (Lieblich, Tuval-Mashiach, & Zilber, 1998).

Narrative research can be simply defined as research done to collect and analyze narrative material obtained through stories, written observations, books, articles, diaries, autobiographies, discussions, or interview data (Lieblich, Tuval-Mashiach, & Zilber, 1998). This study employed the use of interviews since people convey their experiences of events through stories (Clandinin & Connelly, 2000; Frid, Ohlen, & Bergbom, 2000). Storytelling involves the temporal unfolding of events told by narrators in a manner that reflects what the events mean to them. In other words, through storying their experiences, individuals attempt to understand the significant events in their lives (Poirier & Ayres, 1997). Because of this, narrative inquiry is well suited to organize and communicate nursing practice experiences (Frid, Ohlen & Bergbom, 2000). In understanding events of nursing care provided to patients and families, knowledge can be gained from the meanings that are reflected in nurses' stories.

People are natural storytellers. Each story is a representation of an experience expressed in one way at one particular time and is not the experience itself. Each story is considered a representation of a personal reality; that is, a personal understanding of events and experiences (Clandinin & Connelly, 2000; Mishler, 1995; Sandelowski, 1991). The past is linked with the present; with telling, the story can change (Coffey & Atkinson, 1996; Sandelowski, 1991). Sandelowski (1999) states that stories told about past events that have occurred long ago enhances the validity of the findings by allowing the storyteller sufficient time to be reflective of the events. Furthermore, identities and personalities are revealed through stories (Lieblich,
Tuval-Mashiach, & Zilber, 1998). While narrative analysis can help uncover and explain or portray cultural and social norms (Coffey & Atkinson, 1996) of which the nursing group may comprise, this study focused on individual nurses' stories of significant events in nursing practice in which they made an important difference to patients and families.

Narrative inquiry or narrative research involves a relationship between the storyteller (subject/participant/interviewee) and the listener (researcher/interviewer) (Frank, 1998). The researcher, in listening, also observes and pays special attention to the storyteller’s mannerisms, pauses, and silences. Mishler (1986) states that interviews are forms of discourse. The interview is the “joint product of what interviewers and interviewees talk about together and how they talk with each other” (Mishler, 1986, p. vii). Questions of the interviewer and answers of the interviewee develop, reformulate, and are shaped through the interview.

There is a lack of consistency among those who employ narrative methods in the use of the term “narrative”. A number of researchers suggest narratives contain characters, settings, actions, events, relationships, conflicts, resolutions, and/or morals (Lieblich, Tuval-Mashiach, & Zilber, 1998). Others state that narratives are simply the researchers’ analysis of stories told by participants. Others suggest that narratives are stories that have a beginning, middle and end, and contain a plot (Denzin, 1989, as cited in McCance, McKenna, & Boore, 2001). Narratives describe past events and more importantly, state the storyteller’s understanding of those events (Kohler Riessman, 1993). For the purposes of this research, narrative and story were not used interchangeably as they sometimes are by other researchers. Story refers to the words provided by the interview participants and narrative refers to the researcher’s analysis of the stories (Frank, 2000; Poirier & Ayres, 1997).
Sampling Selection and Criteria

In order to obtain rich and pertinent data, purposive sampling was used to recruit participants best able to tell stories that informed the research question. Registered nurses working in critical care areas on a casual, part-time, or full-time basis at a large acute care hospital in Vancouver were the target sample for this study. When participants were initially recruited, any employee of the Providence Health Care facilities who was working as a nurse on a casual, part-time, or full-time basis could participate. In order to obtain a homogenous group whose stories would more easily reveal common themes and narratives, only nurses working in critical care areas were selected.

Recruitment for this study began slowly. Initially, the nurse specialist for education of the facility introduced the research topic in the Clinical Discussion Group monthly meeting. At that same time, she informed those nurses present at the meeting that volunteers were needed for the study and asked if those nurses would spread the word to their respective areas of work. Initially, no one volunteered to participate. The nurse specialist circulated an Invitation to Participate information letter (Appendix B) to various units and these were placed in the communication books located on each ward. The invitation to participate letter provided information concerning the title of the research project, the purpose and objectives of the study, eligibility criteria, contact names, and telephone numbers of the research team. These efforts resulted in the recruitment of the initial participants. These participants were asked to solicit other nurses to participate and were given copies of the Invitation to Participate form to disperse to their colleagues. Through word of mouth, sufficient numbers of volunteers were obtained.

Participants were asked to assist in recruiting other nurses. This snowball sampling technique resulted in the successful recruitment of the majority of participants. In total, 14
participants were interviewed. Interviews with two participants were not used because one participant did not meet the sample criteria and the other participant's audiotape was inaudible and could not be transcribed.

Data Collection

Data was collected in a systematic manner. Once a participant agreed to participate, a convenient time and meeting place for the interview were arranged between the researcher and the participant. Two interviews were carried out in the participants' respective home, two were done in a hospital library, and ten were conducted in each participant's place of work. Interviews were done either on breaks during work hours or on participants' days off.

The sequence of events for each interview was consistent. The researcher introduced herself and reminded each participant of the approximate duration of the interview, and that it would be audiotaped. The consent form was reviewed and signed (Appendix C) and a demographics form (Appendix D) completed. Before beginning each interview, the interviewer read a research synopsis (Appendix E) to each participant to orient the participant to the research topic.

Each participant was interviewed once. Since some participants feel uneasy with the interview process (Morse & Field, 1995), efforts were made to ensure the participants' comfort and special attention was given to decrease or eliminate environmental stimuli as much as possible. One interview conducted at the workplace was difficult to conduct because the participant needed to be close to her patient and the new nurse she was orienting. Thus, the interview was carried out at the nursing station with much noise and activity around. Another interview was conducted in the participant's lunchroom at her workplace where other people came and went; this interview was one of the shortest.
Once the synopsis was read aloud and the participant was comfortable, the tape recording began and some variation of the question, “Tell me about a specific event or situation where your nursing practice made a difference to a patient and/or his/her family” was asked. A list of open-ended questions (Appendix F) was used as a guide to gather stories from each nurse about their nursing practice experiences. Mishler (1986) states that open-ended questions are most effective in obtaining stories since unstructured interviews allow freer responses. And, since minimal intrusion of the interviewer enables the interviewee to structure and sequence their stories of events independently reflecting the storyteller’s unique understanding and interpretation of events (McCance, McKenna & Boore, 2001), the interviewer intervened only to add a probe to clarify points in the story that was told.

Questions were also included to obtain specific information about the invisibility of nursing, the use of technology in nursing, what factors enhance or inhibit nursing practice, how effective are the working relationships among the staff, what nursing interventions were actually used, and most importantly, how the nurse knew whether his/her nursing practice made a difference. The interviewer was sensitive and understanding to the participants and illustrated her interest in what each participant had to say. According to Morse and Field (1995), being a sensitive and understanding researcher who shows interest allows and encourages participants to share stories they feel are important and pertinent to the research topic.

One strategy used in the interviews involved asking the interviewee to picture instances, occasions, or descriptions of specific experiences surrounding phenomena and then conveying them to the researcher in a story (Stuhlmiller & Thorsen, 1997). This method of interviewing was used infrequently to stimulate participants’ storytelling concerning the research topic because the nurses did not appear to find the method helpful in remembering specific events that
would reveal how their nursing practice made a difference to patients and/or families. In response to this difficulty, other strategies were used. In some interviews, the definition of the words "make a difference" was clarified. In other interviews, participants had to be asked to "brag about themselves" in order to obtain stories that enriched the research topic. Questions were individualized to follow the stories presented and each story was explored to obtain detail. Each successive interview changed slightly to focus on questions that best resulted in participant stories that enriched the research topic. When the nurses provided general information about their practice, the researcher requested examples of specific events that supported the general information. To help participants remember specific incidents, nurses were asked to tell stories about an unusual or particularly stressful situation. At the end of each interview, every participant was asked two questions: (a) Is there anything more you would like to tell me; and (b) Is there anything you would like to ask me? Interviews lasted 40 to 65 minutes long. All audiotapes were transcribed verbatim.

Data Analysis

Lieblich, Tuval-Mashiach, and Zilber's (1998) approach to narrative analysis was used in this study. Before analysis began, each transcript was checked for accuracy by reviewing the audiotapes. All pauses, grammatical errors, repetitions, asides, and sounds were included in the transcripts to reflect the inherent structure of spoken language. Attention was paid to how the stories were told, what language was used, and what words were chosen. Mishler's (1986) guidelines for transcription were followed and consisted of the following: the interviewer was labeled "R" and the interviewee "P" representing researcher and participant; nonlexical expressions were labeled as "Hm hm" or "A:ah"; interruptions or overlaps between the researcher and participant were noted by a left-hand bracket "["; pauses or hesitations were noted
Mishler (1995) emphasizes that there are a number of different ways to carry out narrative analysis and suggests that a combination of strategies can be used. One typology Mishler has developed includes three main categories to study and define narratives: temporal order and reference; structure and coherence of the text; and narrative function. In using this strategy, the relationship between real events and how they are ordered in the telling of the story was noted. Additionally, how language and grammar was used and how the story was structured was studied. And furthermore, the function and purpose of the story, the setting in which it was produced, and the effects it had were all considered in the analysis.

Lieblich, Tuval-Mashiach, and Zilber (1998) list four modes for reading, interpreting, and analyzing stories: holistic-content, holistic-form-based, categorical-content, and categorical-form mode. The authors use the four modes to help describe and provide direction to readers conducting narrative research. However, they acknowledge that the categories only represent ideal polarities and that realistically, much overlap occurs. In keeping with a systematic approach, however, and not committing to a particular mode, the interview data was analyzed using the following steps:

1. The interview transcripts were read over many times. The initial reading was one of naïveté and openness. Stories were recognizable as such when the interviewee (storyteller) set the scene for the interviewer (listener), introduced the characters and described their actions, specified events and their relationship over time, explicated a significant conflict and its resolution, and shared with the interviewer the point of the story (Sandelowski, 1991). Mishler (1986) describes these characteristics as structures of
a narrative. During the readings, themes, inconsistencies, repetitions, silences (noted as pauses in the transcript), and endings to stories were noted until a pattern emerged. Themes became evident through repetition of the point of the story or stories shared by the interviewee. Because stories are constantly subject to change as the storyteller makes sense out of events, inconsistencies occurred (Poirier & Ayres, 1997). Inconsistencies therefore signified ambiguity, conflicting feelings, or confusion in the storyteller. Aspects of the stories that appeared more important to the storyteller were noted. These aspects were revealed when the storyteller repeated words and phrases, emphasized and highlighted events or ideas, and revealed emotion when recounting important events. These ways of storytelling became clues that the interviewer used to interpret the meaning in the stories.

2. The researcher wrote down initial and developing thoughts. Inconsistencies as defined above, unfinished ideas, and episodes that appeared to affect the storyteller emotionally were all noted in written fashion. Unusual parts of the story such as contradictions were also noted. Since narrative inquiry allows the interviewer or listener the opportunity to recognize “self” in the participants’ stories, the analysis included notes reflecting these recognitions.

3. Theoretical notes were kept to record developing interpretive ideas as the interview data was examined; that is, themes that reappeared during interpretation of the stories were followed throughout the entire interview and compared to subsequent participant stories. Themes revealed themselves through discourse, repetition, or reference by the storyteller. In this case, registered nurses actively constructed their identity as nurses by emphasizing
what was important in their practice and revealing how that practice made a difference to patients and families.

4. The researcher used color codes to mark themes in passages and read the themes frequently to develop understanding of the content. How the stories were told was examined along with what words were used, why some words were repeated, what purpose pauses held, why particular stories were shared, how the stories ended, and what purpose each story contained.

5. The researcher noted the initial appearance and final exit of themes. How participants used transitions between themes, the manner in which they presented themes, and the importance given to themes were noted. Ongoing consultation between the researcher and the chairperson helped to clarify interpretations and thematic ideas.

Each interview was compared and contrasted with the next until a clear picture was obtained that addressed the research focus of how nurses make a difference in the lives of patients and families. Preliminary findings were shared with 8 of the 12 participants in follow-up telephone calls and their comments on these findings were sought (Frid, Ohlen, & Bergbom, 2000).

A characteristic associated with using interviews in collecting data is that there is sometimes a discrepancy between what the participants say they do and what actually occurs (Poirier & Ayres, 1997). For this reason, the researcher focused on the meaning reflected in the stories rather than trying to document what actually happened. Morse and Field (1995) believe that when interviewers share the same specialized knowledge base as the interviewees, over familiarity with what the participant says may result in relevant data being overlooked with loss of objectivity. Since the interviewer in this study is a critical care nurse and the participants were
critical care nurses, effort was consciously made by the interviewer to effectively explore and analyze data to clarify meaning and regard all of the data.

Poirier and Ayres (1997) state that “over-reading” is a necessary component of narrative analysis. It is the ability to interpret the spoken word by paying attention to the unspoken or indirect statement in addition to noting the obvious. Therefore, inconsistencies, repetitions, silences, and endings were noted to be important aspects of the narratives and are addressed in Chapter Four. The interviewer was careful not to appear to challenge the participants when inconsistencies and repetitions were further probed, which according to Poirier and Ayres (1997) might interfere with the storytelling. The researcher in this project was careful to avoid interfering in the way each participant told his/her story.

Poirier and Ayers (1997), however, also warn that the data may be over-read excessively and that ideas formed by the researchers and analysts may be unrealistic. By following up through with a preliminary member check, participants absolved this problem by supporting the researcher’s interpretation of findings. In addition, open discussion with the chairperson of the MSN thesis committee has also helped prevent over-reading. It is understood though, that narrative analysis by definition is the researcher’s interpretation of the data.

When the interviews were conducted, the interviewer stressed that any story the participant wished to share regarding how he/she made a difference to patients and families was welcomed. The researcher was careful to assess when the participant needed prompting to further explain an idea and when the participant needed to be left alone. This was done in light of Poirier and Ayers’s (1997) warning that some participants feel challenged to defend their narrative and say what they think the researcher wants to hear when asked certain questions or when asked to clarify certain ideas or events. Since the influence the interviewer has on
storytelling cannot be eliminated or avoided, and the discourse between the interviewer and interviewee jointly determines what data will be obtained, how the interviewer influenced the participants’ narratives is another aspect that will be discussed in Chapter Four.

**Evaluation of Rigor**

A characteristic of storytelling is that the stories change with each telling. In this study, each interview was considered fitting to enrich the research topic. Participants were not expected to repeat their stories in a second or third interview. Each interview was considered to be the storytellers’ understanding of past events; that is, their truth of what happened. The interviews served to explore nurses’ perceptions of how their nursing practice made a difference to patients and families.

Lieblich, Tuval-Mashiach, and Zilber (1998) identify four appropriate criteria that can be used to evaluate narrative studies. The four criteria are width, coherence, insight, and parsimony. The first criterion, which relates to the comprehensiveness of the information, was met through the extensive use of direct quotes to report the narrative data. Extensive discussion of the four narratives and a thorough description of the sub-narrative were provided. The researcher’s interpretation of the stories was grounded in the data and direct quotes were used to support the interpretation.

The second criterion, coherence, was met by the construction of meaningful narratives through systematic analysis of the data. Each area of discussion was interwoven into the stories and the interrelatedness of the narratives was highlighted. The sub-narrative was presented as flowing throughout the stories. To complete the requirements of the second criterion, findings are compared in Chapter Five to the existing related literature.
The third criterion, insight, was met by presenting the thesis as a final written report made available to the Woodward Library of the University of British Columbia. The written report accurately represents the meaning of the stories told by the participants and through the researcher's interpretations, provides enhanced comprehension of the research topic. The interpretation of the findings provides insight into nurses' experiences and practices.

The fourth criterion, parsimony, has been met by describing the essential narratives and sub-narrative identified in the analyses. In this study, the presentation of the four narratives and the presence of the sub-narrative provide aesthetic appeal.

To summarize, through systematic and careful examination of the research findings, the interviewer presents a plausible interpretation of the data that provides new understandings about how critical care nurses make sense of their experiences in making a difference to the lives of patients and families.

**Ethical and Human Rights**

The UBC/Providence Health Care Office of Research Services granted ethical approval for this project. Participants were informed of the purpose, objectives and description of the research and asked to sign a written consent prior to being interviewed. Potential benefits were outlined and confidentiality was respected. No information that revealed participants' identities was used and all participants were assigned a code number. All audiotapes have been kept locked in an office and once the study is over they will be erased. All transcriptions and files are locked in an office and the computers used by the research team are password protected. Demographic information was gathered to describe the study participants and does not reveal names.
Summary

Chapter Three has described the methodology that was used to guide this research study. Included in the discussion was a thorough description of the research design, the sample selection and criteria, the data collection method, the data analysis, evaluation of rigor, and ethical and human rights as they pertain to the study. Narrative inquiry was an effective method of research to improve knowledge about nursing practice (Frid, Ohlen, & Bergbom, 2000). Nurses who participated in this study provided stories of how they made a difference to patients and families.
Chapter Four: Findings

Overview

The purpose of this research was to present the findings surrounding how nursing practice makes a difference to patients and families. Interviews obtained from critical care registered nurses resulted in the identification of four main narratives that address this research purpose. The four narratives are Making a Difference Every Day, Going the Extra Mile, Putting Myself in Their Shoes, and Staying Composed in Hopeless Situations. In the narrative Making a Difference Every Day, nurses shared stories about routine work and how that work benefited patients and families. In the narrative Going the Extra Mile, nurses shared stories about using their expertise and determination to overcome obstacles in order to meet patient and family needs. The narrative Putting Myself in Their Shoes focused on the importance of developing relationships as the means by which nurses were able to make a difference to patients and family members. The narrative Staying Composed in Hopeless Situations was reflected in stories of how nurses made a difference by strongly supporting patients and families throughout the dying process. Underlying all four narratives is the sub-narrative It's Not Me, I'm Part of a Team. Nurses portrayed themselves as members of a nursing and a health care team and as such, they described the way their actions were supported and enhanced by others.

Chapter Four begins with a description of the sample that participated in this study. Subsequently, a discussion of the general characteristics of the interviews will by presented focusing on the temporal order and reference, textual coherence and structure, and narrative function of the nurses’ stories as outlined by Mishler (1995). Then a brief synopsis of what participants thought about the statement that “nursing is invisible” will be addressed using direct quotations from the participants’ stories. The different ways participants made sense of the
phrase “making a difference” in their nursing practice is also described. A brief synopsis of the participants and their interviews from which these narratives were derived is included in Appendix G. Finally, a detailed account of the four narratives and the sub-narrative is provided.
Description of the Sample

Fourteen registered nurses who worked in acute care units in one large urban active treatment hospital participated in this study. Thirteen participants met the sample criteria of working in critical care areas. Of the 13 taped interviews, one was inaudible and was not transcribed. With the exception of one nurse, all 12 participants worked as nurses for over a decade. Their experience ranged from under one year to 18 years in critical care. Table 1 summarizes the demographic characteristics of the participants.

Table 1

Demographic Characteristics of the Study Participants

<table>
<thead>
<tr>
<th></th>
<th>Gender</th>
<th>Age</th>
<th>Level Education in Nursing</th>
<th>Area of Employment</th>
<th>Years of Practice: Total/In Present Area</th>
<th>Employment Status</th>
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<tr>
<td>RN #1</td>
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<td>ICU</td>
<td>24/17</td>
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<td>PACU/Stepdown</td>
<td>22/8/1.5</td>
<td>Full-time</td>
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<tr>
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<td>Diploma</td>
<td>ICU/CCU/Cath Lab</td>
<td>15/12</td>
<td>Full-time</td>
</tr>
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<td>ICU, CCU, Cath Lab</td>
<td>19/1</td>
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General Characteristics of the Interviews

Mishler (1986) proposes that narrative studies be analyzed in a systematic way that generates understanding of the selected research topic. One method he employs in analyzing data is adopted from a framework of linguistic functions and includes examining temporal order and reference, textual coherence and structure, and narrative function. Temporal order and reference refers to “how parts of the text are internally connected through various syntactic and semantic devices” (p. 77). Coherence and structure refer to the referential meaning of what is said and narrative function refers to the roles and relationships of speakers involved in the talk. The following section will address each of the three topics as they pertain to the interviews.

Temporal Order and Reference

Mishler (1986) states that people tell stories about events in a number of ways according to the meaning they wish to illustrate or the point they wish to make. One way is to describe events according to the actual sequence that they occurred in real life thereby reliving the experience as it occurred. Another way is to emphasize certain parts of events, presenting them out of sequence in order to highlight remembered parts deemed important. In this study, participants each shared six to twelve stories in their interviews but presented them out of sequence. Initially, nurses began their stories by introducing the patient or family cared for and usually indicated the disease process or injury that caused the patient’s admission to the respective units. Then, however, many stories skipped the actual sequence of events that occurred in real time to focus on the important point or climax of the story. Eventually, through the course of the interview, nurses revealed more details that led to the accumulation of stories rich in data.
Mishler (1986) explains that the order of events told by storytellers determines the meaning of the stories and that by changing the order of narrative clauses can in fact change the meaning. In beginning to analyze and understand the stories, the researcher reconstructed the nurses' stories to mimic real time sequences of events. Without intending to lessen the importance of how the participants chose to share their stories, reconstructing the data facilitated the comparison of stories. So for instance, stories were reconstructed by stating who the “actors” were (patients and/or family members), but including what relevant backgrounds they possessed; followed by what problem(s) arose, but including how the problem(s) affected the patient and family members; and then concluding with the nurse’s role in solving or handling the problem, but including how the nurse felt about the situation. In this way, the researcher began to understand how nurses made a difference to patients and families. Examples of actual participant stories are provided throughout the discussion of the four narratives and the sub-narrative.

*Textual Coherence and Structure*

Mishler (1986, 1995) describes textual coherence and structure, the second component in analyzing the linguistic functions of stories, as how narratives are constructed and how different forms of language are used to create meaning. Included in this analysis are a focus on intonation, pauses, and repetition. In this study, the stories were dominated by medical and nursing terminology clearly understood by both participant and researcher. It was language developed in the culture of nursing that is not necessarily understood by lay people. But while the stories were dominated by medical and nursing terminology, sentences consisted of common English slang and many non-lexical words. In other words, the narratives were imperfectly composed but reflected spoken language between peers. Pauses were used at times as nurses
tried to recall events; repetition was used to emphasize important points; and intonation added interest to the stories.

Throughout the interviews, participants changed tenses to construct their stories. Past tense was used to describe the details of the events surrounding the actual patient and his/her family. Present tense was interspersed in the narratives to emphasize the ongoing practice that occurs in nursing, the truths that continue to be, and the actions that can be applied in similar situations. Future tense was used to tell stories about how certain situations could be handled and about how the participant’s values could be used to direct future actions or reflections.

A number of participants employed the third person to verbalize their feelings about and reflection on certain subjects. Occasionally, participants would begin a story in the first person and would switch to the third person. This action appeared to lessen the degree of acknowledgement and credit due the nurse. For example, this is reflected in one participant’s story about working overtime and how doctors recognized her work ethic:

Well, I only work at how I know how to work. I can’t work at 50%, I’ve got to work at 101% because that’s just me, you know. I don’t like leaving things if I know it’s going to be busy for the two hours I…you know…that type of thing but they recognize it. They’ve come up to me, you know. They know what you do because, you know, sometimes they’ll sit there with us and help with some of the patients for a bit.

Some participants had difficulty recalling stories about how their nursing practice made a difference. These nurses made statements like, “I’m sure I’ll think of something later” or “I’m sure more will come to my mind” reflecting their belief that there are many examples showing how their nursing practice benefits patients and families and that with time, they would remember more stories addressing the interviewer’s requests. This difficulty in recalling stories
will be thoroughly explored in the narrative *making a difference every day*. When nurses recalled stories they tended to focus on the “facts” of the story, implying a lack of embellishment or exaggeration. To heighten the reality of the stories, the nurse participants sometimes repeated the words said by the patients and/or family members.

Sometimes, the participant would ask themselves questions in an effort to refocus the point of their story and answer the question of how their nursing practice made a difference to patients and families; “How would I know? I was just thinking about the answer to that question. How do I know?” or “Did I make a difference? Yes, I think I did.” It was interesting to listen to nurses reflecting on their own practice.

Non-lexical statements were used frequently by most of the participants except for two and reflected that either the events were not clear or that it was important for them to tell the story accurately. For example, while carefully choosing what to say, participants used non-lexical sounds/statements to fill in the gaps. A few of the nurses stated, “I can’t remember the exact details…” but did provide adequate information to make the desired point. For example, one nurse who had difficulty “remembering” the details of an event was still able to recall her actions in an important nursing situation:

> But I remember consulting some of my trusted colleagues about how I would approach this and going – making a private space for us to talk and introducing, not all the concepts at once, but we talked about how a terrible accident had happened and I talked about how their Mommy’s brain was dead, and when your brain is dead how you cannot live, and I think at the end of the night I was left with this deeply satisfying feeling that I had done good work.
Narrative Function

Mishler (1995) describes narrative function as the “work stories do, on the settings in which they are produced, and on the effects they have” (p. 107). Nurses did not choose to tell stories in this study just because the events had occurred recently. The moment in time the event occurred had little influence on whether or not the story was told. Instead, nurses told stories based on the value placed on the events, the impact the events held, and whether a positive relationship was established with patients and families. Nurses told stories in an effort to answer the open interview questions posed by the researcher. They told stories that revealed how their nursing practice benefited patients and families.

Important in analyzing the narrative function of the stories is to consider how the researcher influenced the stories. Participants commonly used the words “right” and “you know” to include the interviewer in the discourse. A number of nurses used the expression “yeah” to back up the factual nature of their stories. In some interviews, shared laughter between the participant and the researcher highlighted the dual understanding of patient/family situations faced by the participant and the researcher who are both critical care nurses. In an effort to please the researcher, a number of participants asked if they were telling the right stories such as, “Do you want me to keep going?” or “Is this what you want to hear?” or “I don’t know if I’m telling you what you want” or “Am I leaving anything out?” One nurse commented after almost an hour of interview that she finally understood what the interviewer wanted to hear.

Another function of the stories involved revealing power imbalances between nurses and physicians even though most nurses stated their relationships with physicians were good. There were indirect implications in the stories that the nurses felt they are the experts regarding much of the patients’ and family members’ needs and are far more sensitive to those needs compared
to the physicians. Most of the participants presented themselves as autonomous practitioners in the areas they worked and stated that the physicians depended on them to inform the course of treatment surrounding the patients. The nurses reflected through their stories a sense of high self-esteem regarding their expertise in their nursing practice.

An additional function of the stories was to stress the importance of sharing stories with colleagues to understand events, improve patient and family outcomes, improve nursing care, and even to acknowledge nurses' work. One nurse revealed that time was made for nurses on her unit to share stories in order to recognize each other's good work. The participants also revealed that story telling was a great way to develop a trusting rapport with patients and families.

The Invisibility of Nursing

Each participant was asked to comment on the belief that nursing is invisible. Most nurses interviewed (10 out of 12) agreed that nursing and what nurses do is invisible. Two nurses considered this invisibility to negatively influence the public's ideas surrounding nursing. One nurse commented:

Nurses should be recognized more. They should be recognized because we can offer a lot of, a lot of things that would save us money in health care…. nurses could be more, almost gatekeepers, almost. Or nurse practitioners. That's a good one! Nurse practitioners. We have to be more visible.

One nurse agreed with the idea that nursing is invisible but believed that nurses were their own worst enemies. Four nurses felt frustrated and annoyed with the invisibility of nursing practice. One nurse suggested that too much is expected of nurses from people who do not understand the scope of what nurses do. Television was viewed as partially responsible for
misleading the public about nursing. Three nurses mentioned the television show *ER* as the worst show to falsely portray nurses.

Some nurses indicated that they tried to inform the public about nursing roles by including the patient’s significant others in the care of the patient and allowing them to see what it is they do in their nursing practice. One nurse suggested the RNABC be more vocal about what nurses do and even suggested that the media is a good resource to use to get the word out. Others seemed unclear as to how to make nursing more visible.

Of the two participants who did not agree with the statement that nursing is invisible, one felt that the idea was a “cop-out” on the part of nurses and the other claimed to have never heard of the idea. The first one felt strongly that if nursing was indeed invisible, it is nurses’ own fault. She believed that nurses must insist on making themselves visible by standing up for themselves, introducing themselves as nurses to patients and others, informing patients and significant others about their roles, and advocating for improved health care standards and conditions.

**Defining the Phrase “Making a Difference”**

Prior to beginning the interviews, the researcher did not expect the participants to ask what was meant by the phrase *making a difference*. In retrospect, it seems odd that more did not wish to clarify the phrase. However, two participants attempted to explain what the phrase meant to them:

Well, you know when you say, “make a difference,” a lot of time you think of making a difference in such a way that you’ve changed someone’s attitude or you’ve helped them to grow in some way or that those sort of big things but that isn’t always the case. You know, making a difference might just mean having a clean bed for them you know?
They’re just comfortable for this moment. And or making a difference could be just the fact that I’m vigilant for that particular patient while I have that particular patient. I’m watching their vital signs. I’m watching their breathing. I’m watching to see if they’re in pain. I’m watching to see if they’re anxious. That could be making a difference.

A second nurse commented:

When you say, “make a difference”, I don’t know what you’re trying to say. Sounds like a life-changing difference. Well, it’s not a life-changing difference. But I’m making a difference in the sense that I’m, you know caring for him and I’m recording observations and reporting observations and noticing things. That you’re noticing, right? It’s like this constant - because you’re there and you have to pay attention. So it’s like you’re paying attention constantly. Of course it makes a difference in that if you didn’t pay attention – especially in this area – things happen, very much. But if you’re asking me…I think it’s defining that. By what you mean by making a “difference” and if I actually overall changed his life, no. No, not to that extent, especially not emotionally. Psychologically, I didn’t change his life. And him personally, my personal relationship with him did not change his life. However, my nursing care definitely kept him may change him, you know, in a safe environment that was promoting his health. As much as I could, so I think it’s sort of a definition [issue].

Through their stories, the nurse participants recounted a variety of ways that nurses make a difference. In the next section, these actions will be discussed as the narratives are illustrated.

**The Narratives**

In the following section, the four dominant narratives identified within the interviews

*Making a Difference Every Day, Going the Extra Mile, Putting Myself in Their Shoes,* and
Staying Composed in Hopeless Situations will be discussed. To begin, a constructed story line representing the narrative will be provided followed by a quote from the interviews that reflect each narrative. Only the story lines are constructed: all quotations used to support the findings are direct quotes from the participants’ interviews. Devices used by the nurses to strengthen their stories to convince the researcher of the veracity of the events will be described. It is important to note that individual nurse’s stories did not exclusively fit under only one narrative but instead, supported a combination of the four story lines. Finally, discussion surrounding the sub-narrative It’s Not Me, I’m Part of a Team will end the section.

Making a Difference Every Day

The basic story line in the narrative making a difference every day is: I make a difference to my patients and their families every day. I notice changes and I intervene appropriately. Sometimes my actions are life saving and sometimes it’s just the little things that I do that people appreciate most. It’s all just part of what I do all the time. The stories that make up this narrative often began with statements about how difficult it was to recall specific stories of making a difference:

There’s probably so many [times I make a difference] - you do it daily and I don’t even think about it. The other day I had a lady who was having a cardioversion and it’s not a big thing to us. It’s just a cardioversion. So she’d never been here and I think I explained everything from top to bottom to her and, you know, there are always little things that can make a difference, you know. She, I was kind of taken back because she was so grateful and wanted my name and all those kinds of things you know. And to me it wasn’t a big thing but to her, just that explanation, just holding her hand while she was going to sleep. To her it meant a big deal, you know. So, that was just recent. So it’s just little things like that you know. That’s just a little example.
Nurses' stories that made up this narrative were all about the day-to-day actions of nurses in critical care. In these stories, nurses portrayed themselves as experts, highly skilled, conscientious, and resourceful people who did their jobs in a responsible and efficient manner. Although the actions nurses described ranged from the mundane to the extraordinary, the stories were all about routine practice. What was consistent across these stories was that the nurses did not boast about their accomplishments. When others acknowledged them, they recounted surprise and, sometimes reinforced the story line by advocating that they were “just doing what was expected” – providing the standard level of care. To give an example, one nurse told a story about receiving an angel pin from a family as a token of gratitude for the nursing care she provided. The nurse was surprised but admitted, “and I just barely remembered the family. I recognized the name and I was trying to search for who he was and I had obviously made a difference to them and they just wanted to send this little thing over. So that was very sweet.”

Embedded in the routines of everyday practice, stories of making a difference did not stand out as memorable events. Nurses used a number of literary devices, however, to convince the researcher that their daily nursing actions were indeed routine and that they were linked with making a difference. To begin, nurses minimized the importance of their role and downplayed the complexity of their nursing interventions that benefited patients and families. For example, even though nurses downplayed the importance of their role in being vigilant and labeled vigilance as routine, being vigilant enabled nurses to notice the smallest change in patient status that then enabled them to respond quickly to avert a negative situation:

All right. The one that really pops into my mind is many years ago and I was working in the CCU and my self and the cardiologist were standing at the foot of my patient’s bed and we were talking to him. It was breakfast and basically he was talking to us and then
all of a sudden, his eyes rolled back and he arrested and the arrest cart was right outside
his room. And I brought it in and I defibrillated him right away and he woke up.... I
would never have told you that story about saving that man’s life had you not asked the
question. I was just doing my job and while the result was very good, it was just part of
my day.

Nurses reinforced the idea that life-saving work was part of their routine practice in the
way the stories were told. The tone of the stories depicted a sense of duty that downplayed the
enormity of the nurses’ experiences in providing extraordinary care. Sometimes the nurses drew
on the metaphor of war to emphasize this point. Like soldiers who are trained to perform certain
tasks and function with indifference to how stressful those tasks might be, highly trained critical
care nurses also carried on despite difficult circumstances to save others. One nurse told a story
that illustrated critical care nurses as the “workers in the trenches”. Other participants calmly
described their work as a “battle” between the nursing staff and the patients’ status and how
nurses “fight” to bring the patient back to health. Nurses spoke of how family members
appreciated seeing them “fighting” for the patient and how sometimes they “win” and other
times they “lose”.

The routine nature of nursing work was reinforced in several ways. The stories were
recalled not because of the extremely positive patient/family outcomes, but rather because
participants remembered being acknowledged for their contribution to the important outcomes of
the event. For example, one nurse described accurately assessing the deterioration of vascular
circulation to a patient’s limb following vascular leg surgery. She intervened and was directly
responsible for setting in motion the preservation of the limb, “I think I remembered it because
they (the doctors) really acknowledged me.”
At other times, these stories were recalled simply because the researcher specifically asked for a story about saving a life or intervening to save a limb. One nurse recalled this story about saving a patient's life through routine care:

We had one boy and he was 21, came in, actually a member of KKK. He got burned while driving in his daddy's 1957 Ford pickup truck on their way to a meeting, with a gas tank in between his legs and they happened to have a head-on collision.... In dealing with him, first of all I had to get over your issues of who he was and what he stood for. That was hard for me but it was most incredibly hard for the black nurses, you know. Giving care and then the family never said anything when the black nurses were there but they wore tattoos. You know, he had tattoos all over him. Like KKK and I guess that was our first hurdle. Secondly he was really sick and, very sick, and he coded, probably 25 times in two months. So it was heroic measures on almost every second shift or every third shift to bring him back and I don't know - I guess that was life saving.

Within this story, the nurse described amazing nursing interventions performed to address this patient's physical needs and return him back to health. This story was revealed because the researcher specifically asked for recollection of a life-saving event. The nurse's last comment reinforced the idea that these events are ordinary. The nurses just did what they had to do as part of their nursing care. In the end, the patient recovered from his injuries and returned home.

When telling their stories, nurses spoke in a humble manner; their stories lacked the detail one would expect to hear in the testimony of providing extraordinary care. By avoiding detail they failed to develop any suspense in the telling and avoided directing attention towards their work.
Lastly, nurses reinforced the repetitiveness nature of their work by focusing on routines. Repetitive stories about providing routine care in critical patient situations made the nursing care practices appear commonplace. The stories illustrated that even though the work was demanding the nurses carried out their responsibilities without difficulty because they had the needed knowledge and expertise required. And since the critical care units demand a high standard of care, the nurses presented themselves as dedicated and able to provide that care: “We have to maintain that kind same standard that is expected. Regardless. You work more but that’s, that’s why I’m here.” One participant, when asked if she could think of an intervention that she did that made a huge difference for a patient, answered:

Nurse: I don’t think over anything that I do all the time.

Researcher: Well, you are on the arrest team right now. Maybe a well-timed precordial thump?

Nurse: Oh, like care of the patient?

Researcher: Well, that’s nursing practice!

Nurse: Yes, that’s nursing practice; recognizing symptoms of a problem and bringing it up and having them find out something ahead of time. Yes, sure,

that’s just assessment. That’s what we do all the time.

This participant’s story supports the idea that nurses in the narrative making a difference every day have difficulty separating what they do from who they are. Nursing work becomes their identity. Many stories ended with a phrase similar to “that’s what we do.” Unfortunately, the inability to separate their identities from what they do reinforces the invisibility surrounding nursing practice.
When prompted to explain how nurses were able to provide patients and families with the care they needed to make important differences, nurses provided a variety of explanations. Several nurses identified their years of experience as being important: “it just comes, it just comes naturally [after working 21 years].” Others suggested it was the ability to balance various patient and family needs on a routine basis that helped them to make a difference to patients and families. One nurse told a story about a very ill patient whose death was imminent. Using her expertise, she gave each family member what he or she needed throughout the experience. One family member needed distraction and support to cope with the situation. Another family member needed information, and a third member needed her feelings acknowledged and heard. A fourth family member needed to bring in talismans and be given the opportunity to place the talismans on the loved one’s body. The nurse described how she easily assessed what each person needed and how she supported each one individually. Yet, when asked how she knew what to do, the nurse replied that it was because of her experience as a nurse. “Okay, that’s what we do. You know. That’s what we do.”

In summary of the narrative making a difference every day, the nurse participants revealed numerous stories that illustrated how their routing nursing practice made a difference to patients’ and/or families’ lives. Because of their expertise, the nurses easily provided care that came automatically and they did not expect gratitude for their work. Despite downplaying the important differences they made, nurses’ acknowledged that patients and families do benefit from nurses providing routine care. When one nurse was asked, “Would you say there’s a patient that your care did not make a difference to?” The nurse answered, “No, I don’t think so.”
Going the Extra Mile (Story of Fortitude)

The basic story line for this narrative is as follows: I make a difference to patients and families by doing everything I possibly can. Sometimes it takes a lot of determination and extra effort to make their hospital experience as positive as possible, but I bend over backwards to do this. Participants recalled many of the stories reflected in this narrative after the researcher asked them to think of a conflict or confrontation surrounding care of a patient and/or family. Responding to this same prompt, the following participant’s quote provides a good example of the narrative going the extra mile:

I think one other time that comes to my mind is a patient that we had who had acute pancreatitis and became a chronic ICU patient and there were many issues around him but one of the issues in his -- he was ventilated for a long time, on TPN, blood transfusions, kept on crashing and he was from the North and he loved his dogs. And I, I advocated for those two dogs to be allowed in. A patient -- that the system was concerned about the dogs clawing on and ripping his trach out and all this and you know, it just becomes -- I think it becomes a myth unto itself. And I just said, “You know, for his healing we need to somehow figure out how to get these dogs in. And that is our job right now.” “You know the dogs, the barking, blah, blah, blah” but you know, we work in the dirtiest environment in the entire hospital and dogs are kind of the least of our problems. And I just remember you know, this is a man who we were giving Ritalin for depression and withdrawal, blah, blah, blah and I’ll always remember the smile on his face. You know, this huge smile when these dogs -- it was a Husky and a little other dog -- came in. And they basically just sat on his bed and it was, and we set up a system so they could come in and whatever on a regular basis. I did remember feeling proud of,
again, advocating for the patient. So I think a lot of it is about deciding what is important to this patient and their family and how can I make that happen.... I think also there has to be an element of passion. That we come to these situations with a determination to make a difference and a passion to make a difference and the, and I think that comes when you work in a workplace that values those things. You know that it's a good thing to be passionate and it is a good thing to take the bull by the horns and go head to head with the system and make things happen.

The above quote reflects a number of literary devices used by the nurses to demonstrate that they benefited patients and families by using extraordinary means. First, nurses emphasized in their stories when they faced peer ridicule, confrontation, or difficulty in meeting patient and family needs. This reinforced the fact that nurses were willing to “get their hands dirty” to go the extra mile. Secondly, nurses expressed passion and protectiveness surrounding patient and family care and were consequently willing to fight for what was needed.

The narrative going the extra mile was about carrying out the unusual, the excessive, and/or the greatest number of possible interventions to make the hospital stay as positive as possible for patients and families. The stories were about nurses who pushed the limit; who acted against the norm or who challenged hospital policies and unit rules to obtain specific care for patients and/or families. In addition to knowing what might benefit patients and families because of their expertise, nurses also learned what patients and families needed while communicating with and listening to them and then advocating for them until the needs were met.

The stories in this narrative provided a number of contrasts to the stories of the narrative making a difference every day. To begin with, in the narrative going the extra mile, nurses
proudly established their role in doing everything possible to help patients and family members. Nurses portrayed themselves as hard-working, assertive, dedicated, imaginative, and determined individuals whose goal was to do whatever necessary to help patients and families. They portrayed themselves as being responsible for setting in motion and/or accomplishing measures to meet specific patient and/or family needs:

We had a patient who was having trouble. Oh! I was helping someone change a dressing. And they had fasciotomies done on their legs but not at our hospital and not done - oh no, they were done at our hospital but they weren’t done the way they’re usually were done. I’ll be diplomatic here. And so when we saw them and we realized that there was extensive tissue damage around the areas, the nurse who was there was new was saying, “This isn’t okay.” There was redness and blanching of the skin all around the area and the lower leg was looking quite bad. So we brought that to the doctor’s attention and he said, “Oh yeah, they know about it.” And I said, “No, they need to know about and they need to get him to come and see it now.” Because when you’re here and you’ve been here for a while you know sometimes they’re new and they’re meek and the doctor says, “I’ll come later.” They just say “Oh, okay.” So if you’ve been here for a while you say, “No, that’s not okay, you need to come now.” Nurses here get very protective of their patients, and what that patient needs, and get very verbal, I think. But I think, but you want someone who’s taking care of your loved ones. And so they did come and see the patient. They paged the doctor that had done the surgery originally who said, “Oh, I saw it yesterday it looked okay. I’ll be in later. I’ll be in a little while.” So they came back to us saying, “He said he’d be in just after lunch.” This was probably about 11:00. So we thought, “Okay, 1:00, maybe not so bad.” And then they came in
and when I went back, 'cause I was on the other side of the room, and I went back later and said, “What's happening with this thing?” And they said, “Well, he came in and looked at it and he didn’t think it looked so bad.” And so I said, “Well, it is bad.” And so then the resident that was on was saying, “Well, I don’t know what to do; I’ve already told the surgeon.” With what we said, “Well, you need to call the staff man and tell him what the problem is.” And at that point the charge nurse was also getting involved 'cause I was making her so involved. And then the staff man said, “Well, you know you have to call him back or” you know. I was getting the story and actually the charge nurse saw one of the vascular surgeons going by in the unit and said, “Can you come and look at this because we’re all concerned and we’re not getting anywhere.” But of course it wasn’t his patient so it was all treading on all those sort of political toes so he came in and said, “Oh my God! This man needs repeat fasciotomies done” and it’s like! And so then that poor resident that was on, because we were frantic, “saying this isn’t good enough” – the nurses - “Do something now! This isn’t good enough.” And the poor resident that was on then had to approach - didn’t know how to then approach the surgeon who had originally seen him who said everything is okay. So they talked to the charge person who said, “Okay, do you want me to phone?” and in fact we were lucky because the vascular surgeon that was on, when that resident phoned the doctor and he said, “What's going on?” the vascular surgeon said, “Oh, well I’ll just tell him I was wandering through the unit and you guys thought it was worse so you talked to me about it.” And he got on the phone and said, “Well, you know I think it’s probably worse than when you saw it.” Very politically correct, but the bottom line is, we got the patient into surgery.
Some of the stories involved nursing interventions that entailed risk, providing another contrast to the routine stories told in the previous narrative where nurses’ interventions were expected and common. In addition, unlike the stories of the narrative making a difference every day, where the nurses did not boast about their nursing care, nurses did boast in the stories that made up this narrative about how they went to great lengths to help patients and families. Doing things against the norm seemed to provide the nurses impetus and gave them underlying “permission” to divulge their personal role in benefiting patients and/or families. In other words, when nurses provided unusual or extra care, they no longer felt they needed to espouse the culture of the “good and modest nurse just doing her work.”

Furthermore, the structure of the stories in the narrative going the extra mile contrasts with the structure of the stories in the previous narrative. These stories were very detailed, evident in the quotes provided in this section. The detail provided reinforced the report of extra effort that was put into providing patients and families unusual or supplementary nursing care. Unfortunately, sometimes going the extra mile ended negatively. The following quote provides a good example of both the detail and the risk found in these stories:

I think we have within our unit a culture of trying to support our families in any way we can because we know that being in the ICU is not a pleasant experience for anyone.... You know, [we] really try to make it as nice as possible for them. And I think that’s just part of our culture that we sometimes well we bend over backwards for families and sometimes, I think sometimes we might even go a bit too far, but that’s another story! [laughs] Well, I think sometimes we have trouble with setting limits, you know. There may be some things that you can do for families and patients that would be very nice for them but because of their condition at the time, it might not be safe for them. One fellow
who was in our unit had a lymphoma and his and himself, their beliefs were they were naturopathic – well she was. The wife was a naturopath and so that was their belief in naturopathic medicine even though she had agreed to come to hospital and he had agreed to come to ICU. So one of the things they really wanted to do was to take him up to the roof gardens so that he could get fresh air, which you know, a great thing to do for him and his family. And it certainly made them feel better but it wasn’t safe. He initially we did take him up to the roof gardens. He was not intubated at that time and we were humming and hawing about whether he really needed to be in the unit or whether he could go back to the unit the floor so, I guess maybe that was okay then. But then he was intubated, and they were taking him up to the roof garden while he was intubated. And anyways, in fact, he did arrest up on the roof garden, in the roof garden. So that’s what I mean about you know bending over backwards for the family. You’re really trying to make it a good experience for them and you’re really trying to go along with their beliefs as much as you can. And yet it was, it was you know, we sort of crossed the line. I think we crossed that line of safety where, we should have been keeping him in the unit even though it was their wish to have fresh air.

By going to great lengths by accessing the appropriate resources and employing advocacy, nurses benefited patients and families by decreasing their stress and anxiety, increasing their ability to cope, addressing their concerns for family accommodation, addressing their psychological and spiritual needs, and ensuring their accessibility to appropriate health care personnel better able to meet certain needs:

They can speak with the physician any time that they want to and I will arrange that for them at any time – that there’s a physician in our unit 24 hours a day, 7 days a week.
And what I also let them know, well basically I try to let them know what services we [laughs] provide. And so I let them know we have a social worker, pastoral care, music therapy, and that sort of thing. Yeah, I just try to let them know what’s available. If they’re from out of town, I try to let them know sort of where the hotels are, and where the restaurants are and that sort of thing. Just to give them some orientation and that our social worker is capable of getting some sort of deals on hotels.

To summarize the narrative going the extra mile, nurses overcame at times huge obstacles to advocate and care for patients and families and in telling these stories, portrayed themselves as “saving the day.” The literary devices used were congruent with what one would expect to find in telling these stories; that is, the stories were told in an energetic manner where nurses sometimes used exhaustive resources to get what they wanted for patients and families. Their stories reflected fortitude and assertiveness in going the extra mile.

**Putting Myself in Their Shoes (Story of Engagement)**

The basic story line for this narrative is as follows: Patients and families are in extremely difficult situations in critical care. I try to imagine what it is like to be a patient and/or family member in that situation so that I can anticipate their needs. By doing this and getting to know them, I provide the kind of nursing care that makes a difference. The nurses easily recalled the stories that made up this narrative, often because they had developed a positive relationship with the patient and/or family involved. Not only did the nurses make an impact on the patients and families, but also the patients and families made an impact on the nurses. The following quote illustrates the narrative of putting myself in their shoes:

Well the one that comes, rings off the top of my head is a very recent story where we had a young patient 35 years old and she had cystic fibrosis and was pretty much at the end
stage of her life. And she came into our unit and it was her choice to do that. She wanted everything done for her even though she knew that it was sort of at the end of her disease process but she wanted every opportunity to try to get over this situation. And, she was a nurse so she knew what that meant. So she came into the unit and we put her on external bypap and hoped that she could get over this exacerbation of CF and possibly get out of the Unit: she was on the list for lung transplant. Unfortunately, we had to intubate her – she got a lot worse - so we had to intubate, which meant that she was off the transplant list. And so of course, that was devastating for the family and also for her as well. They were very upset about that. And they wanted her to have every chance; every opportunity to basically; they wanted every opportunity at to ‘kick at the can’ basically. So [P] now how did I make a difference? I guess what I tried to do was to sort of put myself in their shoes a little bit even though I know I couldn’t possibly do that. But I guess in a sense I tried to anticipate what they were feeling and tried to anticipate what they might need be it information, or just certain ways that I thought maybe they could help with her care and maybe make her feel a little more comfortable. Like little things, like you know, the husband was very attentive and just seemed to need to be able to do something for her – anything - because he felt, well he told me he felt useless. So, you know just little things like I’d asked him if she liked music and she did so I said, “well you know bring in her music and we can set that up for her.” And he brought in her CD player and so something that could make him happy that he could do something for her. It was a small thing but to him, it meant the world to be able to give her something that might make it a little easier for her. And you know just another thing was she was very thin and our beds of course aren’t the most comfortable and he had a big sheepskin for her that covered the
whole bed. So, you know I just made it clear that that was something that was very
helpful for her and “look at her skin” you know “it’s great, there’s no pressure sores.
You’re doing a great job you know having this sheepskin for her.” Just that type of thing.
And I, I’m not entirely sure how I made such a connection with the family, but I did.
And I know that because this family spoke to our Social Worker and told the Social
Worker that how wonderful I was [laughs]. And they just really appreciated my work
and what I was doing for them and they said but you know it was actually not just the
work that I was doing but it was also my demeanor. And sorry, I don’t know what
they meant by that; I didn’t ask so I don’t know what my demeanor was [laughs] but
anyway, that was part of it! [P] So and, also I know that they appreciated my work cause
they you know in the end she did die but and we knew she was going to and the family
knew that as well and I went in just to visit. I wasn’t her nurse at that time but I just went
in just to visit with the family and just so that they knew that I cared [about] what was
happening. And then that was just one of the things her husband said was you know,
“thank you for everything you’ve done for her.” And, you know I just let them know that
the way I felt was that to me it was a privilege that I was able to look after her because
she was quite a person. Like she - you could just - I didn’t get to know her all that well
because a lot of times she was either too weak or she was unconscious, but there were,
you know, times that she was awake. You could just tell that she was someone that you
know, had a drive you know, she had a drive to live and even you know if she was doing
that just for her family or her husband I don’t know but whatever. So, I did get sort of to
know her a little bit and I just – yeah. That was the way I felt - that it was just a privilege
to be able to look after her and I let the family know that.
The stories that made up the narrative *putting myself in their shoes* differed from the stories of the previous two narratives. Unlike the first narrative about routine work benefiting patients and families and the second narrative about overcoming obstacles to provide special care, these stories were embedded in a detailed context of patient and family difficulty that provided the incentive for nurses to become engaged with them. Nurses endeavoured to understand what the patient and/or family were experiencing in order to better meet their needs. Relationships and emotional connections were strongly illustrated in the stories.

Nurses’ stories that comprised the narrative *putting myself in their shoes* were also unique because they emphasized the importance of family. Family members figured prominently in these stories. Families were welcomed into the loved ones’ room and encouraged to retain physical and emotional contact with the patient. Nurses included families in the care plan of the patients when possible. By putting themselves in patients’/families’ shoes, nurses empathized with patients’ and families’ feelings of disempowerment. Their stories illustrated how they tried to offer control and choice when appropriate to help ensure the patient and/or family the dignity they were entitled.

Stories of this narrative emphasized the way nurses felt in caring for patients and families. Nurses described feeling “honored” and “privileged” to care for their patients and families with whom they had developed emotional connections. They suggested that they also benefited from the experience and they admired how the patients and family members coped with their hospital stay.

In reinforcing the difficulty patients and families were having in the context of critical care, nurses employed the use of metaphors. Nurses described the patients’/families’ hospital experience as being “out of this world” and “on another planet” and “foreign.” They also
described patients and family members as feeling like “objects.” Again, in imagining what it would be like to be the patient and/or family member, nurses strived to counteract the feelings of difficulty by the interventions they activated.

Nurses portrayed themselves as concerned and empathetic persons who valued emotional connections and used those connections to support the patients’ and families’ emotional and psychosocial needs. Listening, reinforcing, and acceptance were common nursing measures revealed in the stories. Patients and families benefited by drawing strength from the nurses’ relationships, by coping better with the hospital experience, by not feeling like objects in a foreign land, and by feeling they could talk to the nurse about their fears, concerns, and feelings.

A number of literary devices were used to convince the researcher that nurses benefited patients and family members by putting themselves in their shoes. To begin with, nurses identified themselves as being fellow human beings. This attitude motivated them to provide the same nursing care they would want in reversed situations: “I do what I would like done in similar situations.” It follows that that care would be the best care achievable.

The nurse used words that expressed warmth, understanding, concern, compassion, friendliness, and connectedness. Use of these words added emphasis to the nurses’ commitment to benefit patients and families. The following quote reveals the fondness the nurses developed for an 11-year-old patient who suffered severe burns to both his feet. Providing the boy control over his treatment resulted in a positive prognosis:

And we basically pestered him until, you know, until he liked us. And then he would start asking questions and we started giving him control. Okay! He needed his feet cleaned and it was very painful and he was, he would fuss and fuss and fuss when we did it and when we touched him he would scream. So we said, “okay, you take the forceps,
you take it and you do it.” And he would scrape the heck out of himself ‘cause it was him doing it, not us doing it. So towards the end of his care for the last month we would put him in the tub and leave him for two hours. And he’d do it! And he swam around like a little duck. And it was a blast because it was him: he had control. It was not being done to him: he was doing it.

Paradoxically, some nurses expressed in their stories amazement surrounding the emotional connections made with patients and/or family members while others appeared quite knowledgeable about the reasons why connections were made. What was common regardless of the degree of insight was that nurses portrayed themselves as pleased with having developed relationships. One nurse said: “I have no idea why, why I kind of bonded with her. I liked the family. They were - when the family would cry, I would usually stay there and sort of, stay there, just hold them. And I give them peace and stuff like that. I just bonded with them.” In contrast, another nurse said, “And we ended up you know, forming a rapport because she started to feel like she was heard and that we saw her as a person and saw their lives and, that kind of thing and she began to be, you know; not felt [sic] herself like an object.”

To summarize the narrative about putting myself in their shoes, nurses engaged patients and family members when possible and thereby developed positive relationships and emotional connections. The connections enabled the nurses to make a difference to patients and families in a number of ways. Nurses treated patients and family members as people and provided the same care they themselves would want in reversed circumstances. They found it a privilege to care for patients and families with whom they had developed positive relationships. They supported the family unit and included the family in the care of the loved one. Nurses maintained patient and family dignity by allowing control and choice whenever possible.
Staying Composed in Hopeless Situations (Story of Support)

The basic story line for the narrative of staying composed in hopeless situations is as follows: I benefit patients and families by remaining realistic foremost, positive when possible, and always kind. Although patients often die, I am able to help families and patients realize that positive things can still occur. This might mean that the patient will die pain free and dignified or that the remaining family will grieve in a healthy manner and proceed with their lives. I make a difference by directly helping patients and families deal with poor prognoses by supporting them, providing them information, and guiding them through the initial grieving process.

Numerous stories illustrated the courage nurses showed in dealing with very difficult patient and family situations. The following quote provides an eloquent example of this narrative:

One story comes back to my mind of a woman who had - I can’t remember the details - this was many years ago. Who had, who had I think done harm to herself. I think it was a hanging or, it was not an overdose, it was something, it must have been a hanging. Anyhow, she was a younger woman with two small children and she was brain dead. Her extended family signed her on to be a donor for her organs to be harvested. And my job, as her bedside nurse, and an organ donation program can be quite busy from nursing standpoint. You have to keep the parameters just so, so that the organs remain healthy. But, [I also] was to bring in her children to say goodbye to her. And it was that feeling of “here she is with a beating heart and in a busy ICU and yet we are calling her dead” and bringing those children to a point where not only could they cope with the fact that they needed to understand that their mother had died, but that she was still “there.” And that -
It was just one of those very difficult situations and it was at nighttime so there was not
the care professionals who would have been available – pastoral care and social work.
And, I can’t remember the exact details, but I remember consulting some of my trusted
colleagues about how I would approach this and going, making a private space for us to
talk and introducing, not all the concepts at once, but we talked about how a terrible
accident had happened. And I talked about how their Mommy’s brain was dead, and
when your brain is dead how you cannot live, and, I think at the end of the night I was
left with this deeply satisfying feeling that I had done good work. I wonder sometimes
about these children. What did they take away from that night? But I remember thinking
that I was saying the right things - that I was at least addressing the issue, rather than
brushing these children away because they were at a cognizant age, they were 10 and 12
at the time. And I was very, very intentional on how I wanted the end product to be; that
these children were going to be sent off to grieve in some healthy manner. I, I remember
having a good rapport with them. I remember them asking a lot of questions, which said
to me that they were understanding what I was saying. I remember them crying and me
holding them and I remember the father listening in very intently because I was obviously
giving him the tools that he was going to use later on to answer the questions after the
fact. I did think it made a big difference for that family and I think for one that I
addressed the issues head on because often it’s so much easier to not. Not to allow the
children in or kind of create this illusion that Mommy is still alive but that somehow
she’ll die later on. And not giving them the respect that I felt they were due as her
children to take this - this is going to become their luggage right? Their stuff to carry
around the rest of their life and I think that is one thing I remember again and again when
I deal with families that for me the shift is done but for them this carries on. They take these stories and it becomes part of their life story so I for a very short period of time am part of that life story. And I need to be very aware of that.

Nurses recalled their stories surrounding staying composed in hopeless situations for different reasons. Some nurses offered the stories when the researcher initially requested a story about how their nursing practice made a difference to a patient and/or his family. Others recalled the stories after the researcher specifically asked them to tell a story about an impending death. Nevertheless, stories surrounding a dying patient were numerous, reflecting the fact that many critically ill patients die.

Apparent in these stories were nurses portraying themselves as judicious and kind individuals who would not shy away from their responsibility to assist families and patients face difficult decisions, poor prognoses, or accept the impending death of loved ones. Based in the stories of distressed patients or families faced with grave circumstances, nurses presented themselves as strong supporters who were fully cognizant of their ability to make a difference. This portrayal of the strong, self-controlled, yet calm nurse was a strong element in these stories surrounding death. Nurses provided the “solid rock” for families to lean on and used their experience to provide anticipatory guidance to families throughout the dying process.

The structures of the stories were very detailed, which magnified the complexity of the stories and mirrored nurses’ attention to detail in how they managed the situations. Evident in the stories was how nurses prioritized care around comfort of the loved one first and family members second; orchestrated events surrounding the critical incident, and acted as coordinator of family participation:
One thing I try to do as well is with the wife or the husband; ask them “what is it that you need? Do you want all these people around or do you want time alone? Because you know, death’s a magnet for people. Everyone wants to be there when the patient dies. So I’m a bit of a... I am a gatekeeper.

By staying composed in hopeless situations nurses were able to attend to many details to support families including normalizing patients’ physical appearances:

I try to make the patient look aesthetically pleasing and it makes a difference. Maybe this patient is no better, they might even be sicker, but to the family member, they look great and just, you can hear the relief in their voice. You can see that they really appreciate that. That’s a small thing to wash someone’s hair, make sure they’re shaved, and make them look clean and presentable for the family. Small but makes a big difference.

By staying composed, nurses acted as role models in facing the death directly. They carefully described facing the inevitability of death themselves and then to helping patients and families endure the dying process. Nurses carefully introduced family members to the facts and gently encouraged them to accept the inevitable. In maintaining their composure, nurses benefited patients and families by not abandoning them and by helping them understand their loved one’s diagnosis/prognosis. Nurses also benefited families by encouraging them to carry out religious or spiritual practices, thereby allowing them to begin to grieve in a healthy manner.

To summarize the narrative of staying composed in hopeless situations, nurses expertly guided patients and families through one of the most difficult life experiences; that is, the dying process. Nurses acted as role models in facing death directly and provided families information and anticipatory guidance to help them view death in a positive manner. Nurses ensured that
religious and spiritual practices were carried out because they knew that these practices were so important to the future well being of the family.

The Sub-Narrative

It's Not Me, I'm Part of a Team

A sub-narrative it's not me, I'm part of a team, underlay all the narratives of how nurses benefit patients and families to varying degrees. The story line of this sub-narrative is as follows: I make a difference to patients and families by being a member of two teams; a nursing team and a health care team. Together, we work to provide the patient and family as much support as possible in the critical care setting. The following quote illustrates this sub-narrative:

So when a patient comes into the unit generally we need a bit of time just to settle them in. Depending on the patient and what’s happening with them we might need a little more time to put in lines, that sort of thing, get them a little stabilized. And during that time if there’s family they’re usually out in the waiting room and we’ll get the assistant head nurse or whoever’s in charge to go out and talk with the family to just let them know what’s happening, and that they will be able to come in and see them but that we’re just doing x-rays or whatever it is that we’re doing. So when the family comes in you know we try to explain to them what all these gadgets are because in ICU there’s a lot of equipment so we try to tell them, you know what some of this equipment is for.... And let them know about the physicians that we have and that our physicians, our staff men change every week and then they at any time – that there’s a physician in our unit 24 hours a day, 7 days a week. And what I also let them know, well basically I try to let them know what services we [laughs] provide, and so I let them know we have a social
worker, pastoral care, music therapy, and that sort of thing. Yeah, I just try to let them know what's available. If they're from out of town, I try to let them know sort of where the hotels are, and where the restaurants are and that sort of thing. Just to give them some orientation and that our social worker is capable of getting some sort of deals on hotels.

While sharing stories with the interviewer, participants frequently used the pronoun we. Often times, they would tell a story using the first person I, and switch to we. In only the strictest instances when just the individual nurse was involved in an event did she/he solely use the pronoun I, or first person. The frequent use of the pronoun we was the fundamental literary device used by the nurses to convince the researcher that nurses identified themselves as being members of teams. In addition, nurses frequently used the words “team,” “team effort,” and “team player” - one nurse even insisting she wanted to be a “good team player.” The type of team referenced, whether it was the nursing team or the health care team, was dependent on the topic of the nurses’ stories.

Consistent throughout the narrative it's not me, I'm part of a team, was that team work was clearly linked to benefiting patients and families because of the comprehensive and effective characteristics of that work. Of importance, and dominant throughout numerous stories, was that nurses portrayed themselves as the primary links to the various caregivers. For instance, in order to meet specific patient and family needs, nurses accessed specific members of the health care team. Sometimes, the sheer number of team members assembled by nurses resulted in the most effective care:

When I had that really busy patient and I had two nurses in my room who were absolutely fabulous in helping me, and just being able to go with the flow of the
day. And, you know, so I’m late getting out on my break and they’re late getting on their break, but nobody really gets too angry about it but just help the patient like – and everybody’s willing to shuffle, rearrange, just be flexible enough to, you know, make the best for the patient. What’s best for the patient, you know.

Characteristics of this sub-narrative were numerous. To begin, nurses identified themselves as team members and referred credit for positive patient and/or family outcomes to the team effort. In addition, nurses demonstrated pride in their stories about being members of a team. It was unmistakable that teamwork was highly valued. Moreover, nurses expressed a sense of shared responsibility for patients and families, “we rely on each other” and conveyed feelings of confidence that as a team, all patient and family needs could be met, “If I need help, I can get help from anybody. It’s not a problem. Getting help has never, ever been a problem. [This hospital] is absolutely wonderful for that in that we work as a team.”

Another device used by some participants to reinforce the importance of teamwork was to draw contrasts between well-staffed and poorly staffed units or situations:

I feel sometimes it’s the lack of staffing that hinders my care. Because you know as I was talking to you earlier, you know. It’s very unsafe sometimes with the limited amount of staff we have. There’s a shortage of nurses, obviously you know, that’s nothing new right now but I find sometimes there is not enough staff to look after and to give appropriate care - that you want to do for the patient. With care you want to, you know, there’s not much time to sort of sit down and comfort the patient in the way that you want to do it. You’re always pushed. You know you have to run around, do other things in order to get everything done. Sometimes the family’s there and there’s only so much
time to get involved with them. You know, to find that, that’s very hard on us is the shortage of the staff.

To summarize the sub-narrative *it’s not me, I’m part of a team*, participants emphasized how they were better able to make a difference to patients and families with the support of the nurses on duty during any given shift and with the support of the larger health care team available. Each team member had a particular role and was able to address specific needs of patients and family members. By working together, the patients and families were provided comprehensive and efficient care.

**Summary**

The four narratives and the sub-narrative provide important information about the way nurses story their experiences to illustrate how they make a difference to patients and families. Participant stories enhanced our understanding of what nurses believed they needed in place in order to make the greatest difference; that is, adequate levels of staff, the presence of nursing and health care teams, knowledge and experience, and the energy and ability to engage families and to develop positive relationships and emotional connections. In the stories nurses presented themselves as hard workers who were committed to maintaining a high standard of care.

Nurses constructed stories of making a difference in the context of providing the kind of routine nursing care that is expected of critical care nurses. They did not expect, therefore, to receive special acknowledgement for their work. Nurses illustrated they possessed the knowledge and determination necessary to enable them to make the hospital experience as positive as possible. Relationships developed between nurses and their patients/families allowed them to imagine what the patient and/or family was experiencing. That information was used to
provide patients and families the care they required. Nurses also provided the needed support
during grave situations and assisted families begin the grieving process. Finally, nurses were
able to ensure comprehensive care by being members of nursing teams and health care teams.

The storytellers presented themselves in such a way as to emphasize how nursing practice
benefited patients and families. Their stories reinforced their identity as nurses by the
commonality of the situations presented. These critical care nurses reflected the interviewer’s
belief that patients and families benefited in various ways and by incredible means from the care
provided by those nurses.
Chapter Five: Discussion and Implications

Introduction

Chapter Five begins with a brief summary of the findings from Chapter Four. Limitations of the study will be presented next. Selected findings are then discussed including how nurses perceive that their practice makes a difference; the invisibility of nurses’ work; the implicit values in nurses’ descriptions of their practice; and family roles in the critical care area and how nurses support these roles. Finally, implications for nursing practice, education, and future research will complete the chapter.

Summary of Findings

As illustrated by the findings in Chapter Four, the participants presented themselves through stories as caring and resourceful nurses who are committed to making a difference to patients and families through their nursing practice. Analysis of nurses’ stories revealed four primary narratives. In the first narrative, making a difference every day nurses’ stories were about providing competent routine nursing care. Some stories illustrated life-saving events and others consisted of the little things that nurses did that resulted in clear demonstrations of appreciation by patients and families. In providing daily care, nurses did not expect others to recognize their individual efforts to benefit patients and families. Instead, they considered the care simply part of their jobs.

The second narrative, going the extra mile, was reflected in stories about how the nurses made a difference to patients and families by doing everything possible to make the hospital experience as positive as it could be. In these stories nurses emphasized how they challenged norms, went against hospital policies, and sometimes confronted with colleagues and other health care members to ensure patients and families received the care they needed.
In the third narrative, *putting myself in their shoes*, nurses' stories of making a difference involved imagining what it was like for their patients and families to be in the hospital. Nurses described how they tried to anticipate what patients and families needed and then went about meeting those needs. They presented themselves as empathetic caregivers, listening to patients and families and treating them as they wished to be treated if roles were reversed. They explained that they developed positive relationships with their patients and families and that these relationships enabled them to provide the care that made a difference.

In the stories that made up the fourth narrative, *staying composed in hopeless situations*, nurses described situations where they provided support to patients and families throughout the dying process by remaining realistic yet positive and always kind. Despite the emotional difficulty ingrained in these situations, nurses portrayed themselves as courageous supporters who did not shy away from helping the family begin the grieving process. Because nurses stayed composed they were able to devote their entire attention to patients and their families and focus on ensuring that dying patients experienced a pain-free and dignified death. At the same time, nurses encouraged families to express cultural, religious, and spiritual practices.

Underlying all the narratives was the sub-narrative, *it's not me, I'm part of a team*. All participants emphasized how important teamwork was to provide the best care possible to patients and families. Nurses positioned themselves as members of nursing teams and members of health care teams who work together to meet all patient and family member needs. Nurses identified themselves as team members who were surprised when their individual work was acknowledged.
**Limitations of the Research**

The findings of this study need to be considered in light of three limitations. The main limitation of this research is that the study involved a small sample. Only 12 participants were recruited. Other stories may have been heard had more nurses been included in the study. Including nurses who work in different contexts may have provided greater variation in stories about how nurses make a difference to patients and families. The majority of the participants recruited worked in areas that seemed to be sufficiently staffed and that endorsed a team approach. This inevitably enabled the nurses to provide a high quality of nursing care, which in turn, influenced the types of stories shared.

A second limitation of this research relates to data collection. The majority of nurses only agreed to be interviewed during work hours when they were on breaks meant for nourishment and relaxation. Few were willing to meet outside of work. In addition, no tangible compensation was awarded the nurses for participating. These factors influenced the degree to which nurses were engaged in the interview process. The best interviews were conducted when the participant was fully committed to storytelling.

A third limitation relates to the interview process. When participants provided general information but did not include stories about specific patients or family members, the researcher became more directive in requesting specific examples of events and at times provided specific suggestions as to the types of stories that were the focus of this research. This more directive approach may have influenced the kind of stories that were told. The influence of the researcher was also indirectly demonstrated in the interviews. Participants occasionally interrupted their own stories to check with the researcher regarding whether the content was wanted and whether they should continue. Despite these limitations, the findings provide some important insights
about how critical care nurses perceive that their practice makes a difference to patients and their families.

**Existing Literature About How Nurses Make a Difference**

The narratives identified in Chapter Four represent nurses' stories that indicate important ways nurses made a difference to patients and families. In comparing the findings to the existing literature, the existing literature was found to be supportive of how nurses make a difference. Benner's (1984) description of expert nursing practice is comparable to the findings of the present study. Although Benner did not use narrative inquiry, she did study critical care nurses and their practice. She drew on nurses' stories of significant nursing care events to investigate how nurses learned over time to become expert clinicians. She concluded that nurses' practices of helping, teaching, coaching, diagnosing and monitoring, effectively managing rapidly changing situations, administering and monitoring therapeutic interventions and regimens, monitoring and ensuring quality health care practices, and of being organized and competent, were important and highly skilled ways nurses intervened with patients and families. These same practices were evident in the stories shared by the nurses in the present study and figured prominently in the narrative of making a difference everyday in which nurses described their routine work.

Madjar and Walton (2002) conducted a research study also concerning how nurses make a difference using narrative inquiry. The impetus to do the research stemmed from their concern that the public knew little about nursing and that despite the important roles nurses played in patient and family care they were never considered individually responsible when positive outcomes resulted. They contended that nurses’ stories could be used to enlighten others. Using interviews to gather stories, 46 critical care nurses were asked to describe an incident about how
they as nurses made a difference. The vast majority of stories were about relatively ordinary events that had an unusual turn of events.

Akin to aspects of the present study, Madjar and Walton's (2002) findings revealed three main narratives that portrayed nurses' work as acts of heroism: stepping out of line, risking criticism from colleagues, and working for patients' best interests. Stories that made up the narrative *going the extra mile* in the present study especially reflected Madjar's and Walton's first two narratives where nurses did whatever they could to make the hospital experience as positive as possible by advocating strongly for their patients and by challenging customary practices, rules, and policies even when it resulted in receiving criticism from colleagues. Stories that reflected how nurses worked for patients' best interests dominated the narratives in the present study. Madjar and Walton’s findings that the vast majority of stories were of ordinary events are consistent with the present findings where nurses made a difference every day through their routine work.

Like the present study, Madjar and Walton's sample consisted of critical care nurses. While it might be argued that nurses who have specialized knowledge and who work in critical care areas are more autonomous and have the fortitude and desire to make a difference, Reutter and Ford's (1997) study of public health nurses revealed similar findings. The purpose of their qualitative research was to describe how public health nurses provide information to enhance client competence. They reported that nurses made a difference through sharing expert knowledge and building on patients' knowledge. Professional knowledge provides patients and families with different ways of coping with situations, in the present and in the future. Similarly, the nurses in the present study repeatedly emphasized the importance of providing information and building on patients' and family members' knowledge to help them cope with the hospital
experience and to use for future experiences. While public health nurses and critical care nurses perform different types of work, they share a sense of responsibility that they must address all patient and family member concerns.

All of the nurses in the present study told stories about the physical care of patients' bodies. Lawler (1991) and Buresh and Gordon (2000) identified the significant benefits of nurses' work surrounding this care. They described how nurses used their expertise when providing physical care to not only obtain information about patients' physical status and future needs but also about their psychological, emotional, and social needs that could then be used to provide holistic care. While nurses in the present study obtained this information from patients who were able to verbalize, oftentimes, their patients were heavily sedated or unconscious and unable to express concerns. In end-of-life situations, nurses obtained information regarding psychological, emotional, and social needs of patients while conversing with specific family members who were included in helping with patient care. In their stories, the nurses repeatedly emphasized their efforts to protect patient dignity at all times regardless of the patients' level of consciousness. These findings suggest that the nurses' desire to maintain patients' dignity and continually explore patients' needs may be an important factor in their ability to make a difference to patients and family members.

There are a number of doctoral dissertations that report research findings comparable to those of the present study even though various methodologies were employed and different kinds of nurses were sampled: such as, nurses or student nurses from different work areas. Chiara (1993) noted in the findings of an ethnography of women's career motivations, values, and work satisfaction in nursing that nurses made a difference to patients by helping them manage their diseases. Neil-Urban's (1994) phenomenological study revealed that student nurses made a
difference by maintaining hope and by committing to patients’ well-being. In a phenomenological study on nurses working in the addiction field, Conti-O’Hare (1995) found that nurses made a difference through mutual growth and development that included risking self and establishing mutual trust. Findings from a descriptive study revealed that psychiatric nurses made a difference by using their personal power to influence patients in a positive manner (Kearney, 1995). Finally, Wolf (1989) concluded through a phenomenological study that nurses made a difference by valuing patients’ individuality and wholeness. Although these research findings bear some similarities to the ways nurses depicted themselves in stories of making a difference in this research, there are some important differences. The findings of this study provide evidence of the capacity of critical care nurses to make a difference in multiple ways, using a wide range of strategies in highly complex and emotionally charged situations. The controlling factor that makes critical care nursing different is that patients are acutely ill and often facing life or death issues beyond their control. Additionally, family members are facing desperate situations and depend on the nurses’ expertise to help them cope. Using their specialized knowledge, the critical care nurses were able to accurately assess the needs of patients and families in varying stages of crisis and used this information to plan nursing care that made a difference. Findings from this research suggest that nurses’ positive attitudes, autonomous practice, high level of expertise, ability to endure high levels of stress, ability to work as team members, strong work ethic, and high sense of responsibility all contributed to the nurses’ ability to make a difference.

**Invisibility of Nurses’ Work and What Contributes to This**

The findings of this research support claims about the invisibility of nurses’ work.
In their stories, nurses portrayed themselves as hard workers who took their own expertise for
 granted, downplayed their individual efforts that created positive health outcomes, and
 unassumingly went about their day-to-day activities never expecting acknowledgement. A large
 number of nurse theorists and researchers agree that this behavior increases the invisibility of
 nurses' work (Benner, 1984; Parker & Gardner, 1982; Paterson & Zderad, 1976). In addition,
 the study findings revealed that nurses' stories reflected the use of military terms and metaphors
 in describing nursing practice, a phenomenon that many authors claim contributes to the
 invisibility of nurses' work. For example, Mitchell, Ferguson-Pare, and Richards (2003) argued
 that historically, nursing practice was developed using the military framework that endorsed
 blind obedience to unquestioned authority. They believed that the continued use of military
terms and metaphors by contemporary nurses obscures the unique contributions of nurses. Also
characteristic of the military ethic was the dominance of teamwork (Kerr & MacPhail, 1996;
Mitchell, Ferguson-Pare & Richards, 2003; Parker & Gardner, 1982; Wurzbach, 1999). The
nurses' stories described teamwork as being dominant in the way their work was structured,
contributing to the invisibility of their work as individuals. Furthermore, nurses had to maintain
patient confidentiality, enforce visiting restrictions, and protect the privacy of patients and their
families during their hospital stay, actions that also contribute to the invisibility of nurses' work.
Again, researchers agree that the private nature of nurses' work contributes to their invisibility
(Benner, 1984; Cheek & Rudge, 1994; Kenny, 2002; Lawler, 1991).

In nurses' stories, the ongoing psychological, emotional, and spiritual support they
provided in conversations with patients and families was portrayed as important work that took
much time and energy. Cheek and Rudge (1994) concluded that the importance and impact of
nurses' conversation while providing supportive, restorative, and continual care is lost in the
day-to-day activities of nurses. This talk is not charted or captured in any way other than to communicate to patients, families, and other health care professionals. Through their talk, nurses treat patient and family situations as ordinary and thereby show acceptance of patient circumstances and catastrophic events. Nurses skilled in their practice take for granted their ability to consider things ordinary (that are otherwise extraordinary to lay people). Nurses talk with each other but often refrain from sharing experiences with others not comfortable with illness, injury, disease, and death (Rashotte, Fothergill-Bourbonnais, & Chamberlain, 1997). This also contributes to the invisibility of nurses’ work.

In the present study, a number of nurses told stories about relatives who did not understand nurses’ scope of practice, who did not want to hear about what nurses do, and who held incorrect assumptions about nurses’ work. A number of participants stated their frustration when trying to explain their work to non-medical people and blamed poor depictions of nurses on television shows as responsible for some misguided views. Parker and Gardner’s (1982) conclusions support the findings that non-medical people misunderstand what nurses’ work entails. They studied narrative accounts of significant life experiences through an examination of nurses’ documentation. They found that the documentation vastly undervalued the complexity of the work nurses did and that nurses only recorded the treatments provided and the physical status of the patients. The documents failed to reflect the psychological, social, and emotional aspects of nursing care. Instead of documenting their expertise, Parker and Gardner found that nurses preferred to talk about it. But nurses could only successfully talk to other nurses about nursing practice since non-medical people did not understand or were not interested in hearing about the details of nursing practice.
Although nurses continue to express frustration that some people continue to believe that nurses are an extension of physicians, do not think independently, and are loyal and submissive, factors that contribute to the invisibility of nurses’ work (Bonnell, 1999; Parker & Gardner, 1982; Wurzbach, 1999), the narratives in this study present a much different picture of nursing. Instead, the nurses’ stories reflected feelings of autonomy and control in working in the critical care areas. The nurses felt valued by the physicians and knew their patient and family assessments guided physicians’ orders. They presented themselves as highly skilled practitioners who competently applied expert knowledge and collaborative practice to deliver patient and family care. Many nurses conveyed feeling a sense of power over patient and family care.

**Nursing Values Reflected in the Narratives**

Chinn and Kramer (1999) define professional values as “beliefs and ideologies that are generally held in common by members of the profession and are used to guide professional action,” and individual values as “an individual’s commitment, personal philosophy, motives, beliefs, and priorities” (p. 42). While one can write extensively about possible nursing values, this section will address the most obvious ones embedded in the nursing stories examined in this study.

The nurses’ stories implied that nurses valued competency and modesty with respect to their daily work. Related to competence, nurses valued expert knowledge and skill, composure under stressful situations, and the ability to manage any event or circumstance. They valued people as individuals and placed great worth on life. Advocacy, empathy, and autonomy were evident as major values implicit throughout the many stories as nurses made differences to patients and families. In describing how they went out of their way to benefit patients and families, nurses implied valuing imagination and fortitude to get things done. In telling stories
about putting themselves in their patients’ and families’ shoes, nurses implied valuing honesty and respect. Additionally, nurses valued the well-being of patients and family members and went to great lengths to provide comfort and maintain dignity. But most importantly, nurses valued the relationships developed with patients and their families.

Existing research concerning nursing values is extensive, reflecting the inherent importance placed on them. The values identified in other studies are not unlike those reflected in the findings of this study. For example, Wolf’s (1989) doctoral dissertation about the identity of nursing relative to medicine concludes that the core values of nursing consist of individualism and wholeness in life and that those values are manifested in caring behaviors. Similarly, Benner (1991), Leininger (1984), Wros (1993) and others identified caring as the value that guides nursing practice. Benner (1991, 1994, 2003) concluded in her studies that nurses value autonomy to foster patient and family self-reliance; acceptance and respect to develop positive nurse-patient relationships; and comfort to relieve patient suffering and ensure patient dignity.

Paterson and Zderad (1976) developed a humanistic nursing theory based on their study of the experiences of nurses. They concluded that a fundamental value guiding nursing practice is related to human potential; that is, the belief that humans can become more as humanly possible in each particular life situation. They theorized that nurses make themselves available to respond to patients’ needs and to help them attain their highest potential. Other values identified by these nurse theorists as guiding nurses’ work were similar to those implied in the present study. They included valuing authenticity and genuineness, personal freedom, and humanness.

Bishop and Scudder (1991) studied the meaning of being a nurse using narrative methods. They also concluded that nurses valued authenticity, valued the well-being of patients
and families, and valued excellent practice in caring for others. Their findings identified the value of advocacy as guiding nurses in their efforts to coordinate care for patients and families as did other researchers (Landahl & Sandman, 1998) and that nurses valued relationships with their patients/families.

Raatikainen (1989), whose doctoral dissertation dealt with values and principles in nursing, concluded that love is the value that guides nurses' work. *Love* in nursing was defined as "actively caring for the well-being of a human being in need, which often promotes the personal growth of that individual" (p. 93). In making a difference every day, nurses promoted the personal well-being of patients and family members by identifying and addressing their needs.

To summarize, nurses hold personal and professional values that guide their nursing practice. The findings of this study reflect important values held by nurses that are also supported in the existing literature. One can speculate that if nursing practice makes a difference to patients and families and values guide that practice, then it may be the presence of those values, in conjunction with clinical expertise and critical thinking, that enables nurses to make a difference.

*The Role of the Family in the Critical Care Unit*

Nurses care for critically ill or injured patients and act as resources for their families. As stated by a number of nurses in the present study, family consists of whomever the patient identifies as such. Many stories revealed how important individual family members were and how vital the family unit was in providing support networks for hospitalized loved ones.

Family systems theory defines the family as an interdependent unit whose individual parts (family members) continually interact (Bernstein, 1990). Because of this, families as a
whole consider the hospital experiences a crisis and efforts to promote family adaptation and emotional stability are recommended. An important nursing goal in any clinical setting is to maintain the integrity of the family unit throughout the hospital stay of a loved one (Gavaghan & Carroll, 2002). The nurses in the present study told many stories about how their work benefited families. They often illustrated how important it was for them to keep families informed by providing them honest and accurate information, to listen to their concerns, to provide them emotional support, to access other health care disciplines to meet their needs, to respect them, to treat them with dignity, and to be accessible. The nurses often depended on family members to supply needed information about loved ones who could not speak for themselves. Similarly, numerous published research studies support the importance of interacting with families in these ways (Bailey, 1989; Cohen & Dawson, 2000; Jezewski & Finnell, 1998; Kosco & Warren, 2000; Murphy, Forrester, Price, & Monaghan, 1992; O’Malley, Favaloro, Anderson, Anderson, Siewe, Benson-Landau, Deane, Feeney, Gmeiner, Keefer, Mains, & Riddle, 1991; Reider, 1994; Tin, French, & Leung, 1999; Turton, 1998; Westlake & Dracup, 2001; Yates & Stetz, 1999).

The roles of nurses in interacting with families documented in the literature are reflected in the findings of the present study. It was often through families that nurses were able to make a difference to patients. Families not only provided support to loved ones but also represented and voiced the wishes of their loved ones and provided vital information to nurses’ and other health care professionals about their significant others.

Findings from studies examining what is important to family members of hospitalized loved ones have led to numerous changes in hospital policies and nursing practices (Gavaghan & Carroll, 2002; Hammond, 1995). The nurses in this study confirmed that their hospital’s policies and nursing practices have changed to provide improved patient and family
care as a result of research. For example, Hammond (1995) used a descriptive survey design to
describe the attitudes of intensive care nurses and relatives concerning the provision of care by
relatives to their critically ill loved ones. Findings revealed that families felt they were helping
their loved ones when they were included in patients' physical care. Families also identified the
need for knowledge and information to help empower them, which sometimes meant being
allowed to witness life-saving interventions involving their loved ones (Gavaghan & Carroll,
2002). In the present study, nurses told stories about including family members in the physical
care of their loved ones and in planning the direction of ongoing patient care. They told stories
about family members' involvement in witnessing life-saving measures. The healthcare team,
assembled when needed to provide the family information, answer their questions, and discuss
the patient's status, would in turn, depend on family members to provide information
surrounding end-of-life wishes of a reticent loved one. This was another important family
function identified in the literature (MacPhail, 1996; Miller, 1992).

Gavaghan and Carroll (2002) examined the literature surrounding families of critically ill
patients and concluded that families also needed to be able to visit loved ones at any time and
sometimes include pets when visiting. Caine (1991) concluded that the family unit is important
in positively supporting patients. The nurses' stories in the present study reflected the importance
of the family unit in positively supporting patients and revealed that nurses purposefully
modified visitation times and regulations to accommodate families. They even included pets as
family members when patients indicated them as such. Existing literature prominently supports
the importance of families' efforts to sustain a sense of hope and allay patients' fears through
spiritual means (Bays, 2001; Bland & Darlington, 2002; Cohen & Dawson, 2000; Ebright &
Lyon, 2002; Herth, 1995, 2000; Kaba, Thompson, & Burnard, 2000; King, Rowe, Kimble, &
Zerwic, 1998; Saleh & Brockopp, 2001; Sellers & Haag, 1998; Weil, 2000; Westlake & Dracup, 2001; Yates & Stetz, 1999). The nurses’ stories described how nurses went out of their way to support families in carrying out cultural, religious, and spiritual endeavors that they believed would help loved ones.

In summary, the nurses’ stories supported the existing literature surrounding the importance of the family in positively affecting loved ones in the critical care hospital setting. Nurses’ stories emphasized how nursing practices have evolved to accommodate the family unit with the goal of providing comprehensive care.

**Implications**

This section will briefly discuss nursing practice implications, nursing education implications, and implications for future research as they relate to the study findings.

**Nursing Practice Implications**

The nurses’ stories have highlighted the many ways critical care nurses believe they are able to benefit patients and families. The stories also revealed how the nature and structure of nurses’ work contribute to the invisibility of nurses’ work. When directly asked for suggestions of how to increase nursing’s visibility, the nurses responded with a number of suggestions. Various nurse researchers and authors support these suggestions as being productive in increasing nursing’s visibility (Benner, 1984; Chavasse, 1998; Gavaghan & Carroll, 2002; Hammond, 1995; Jamieson, 1998; Ohlen & Segeston, 1998; Roberts, 2000). For example, the nurses suggested the importance of always introducing themselves to patients, family members, and other health care professionals. The nurses suggested keeping patients and families informed about their roles in patient care and stressed the need to continue to demand that their
voices be heard. One important way of doing this is to change the way they document their nursing care, making the emotional and supportive work more visible.

The nurses also encouraged other nurses to acknowledge the important individual roles they played as members of teams, to take pride in their work, and to welcome acknowledgement. Some nurses suggested that individuals be recognized and their good work celebrated by colleagues on a regular basis. A few nurses suggested that by becoming involved in policy-making and political parties, nurses could increase their visibility. Other nurses believed that storytelling could be used in all nursing areas to make nursing more visible. Some nurses also voiced concerns about television shows that falsely portrayed nurses' work. They suggested the professional nursing bodies, such as the Registered Nurses' Association of British Columbia and the British Columbia Nurses' Union could inform the media of nurses' complex roles and emphasize that nurses do require specialized education to provide nursing care. It appeared that these nurses might not have been aware that the Canadian Nurses' Association presents media awards for accurate nursing depictions and that the American Nurses' Association monitors the media, since the nurses did not refer to any particular initiatives. As a final suggestion, the narratives identified in this study could be used in a variety of ways to help administrators, nurses, other health care providers, and the general public to understand nursing practice.

**Implications for Nursing Education**

In response to the higher patient acuity levels, the ongoing need for nursing research, and the increased level of expertise required by nurses, the entry level into nursing is now an undergraduate degree. As students enter practica with expert nurses, nurse educators could help students focus on how skilled nurses make a difference through verbal discussions of observations. Findings from this research suggest that nurses' ability to be autonomous, to have
a high level of expertise, to competently function in a critical care work environment, to work as a team member, to adopt a strong work ethic, and to possess a high sense of responsibility appear to contribute to nurses' abilities to make a difference. These areas of knowledge and skill could be reflected in all nursing curricula for critical care nurses.

Findings from this study suggest that important nursing values play a role in enabling nurses to make a difference. Therefore, nurse educators need to continue to explore ways of teaching students how to develop an awareness of their personal and professional values and how those values shape their nursing practice. Nurse educators and university recruiters could continue to inform people considering nursing as a career that nursing practice makes a vital difference to patients and families.

**Implications for Future Research**

This study has brought up a number of topics that warrant further research. The findings have identified various factors that appear to positively influence nurses' ability to make a difference to patients and families. One of the factors that may have influenced the findings is nurses' expertise and ability to work in a critical care environment. In order to investigate this more, further research could be done to investigate how nurses working in different work settings make a difference. Examining perceptions of making a difference and whether nursing and/or patient outcomes are actually achieved could provide important information regarding nursing practice outcomes.

Findings from the study also suggest that being able to work as a team member influences nurses' ability to make a difference. Other kinds of studies to extend our understanding of making a difference might include observations of actual nursing care situations. Research could focus on observational studies to determine what factors enable or
inhibit nurses' ability to make a difference and to describe patient and family outcomes associated with nursing actions. Findings from these suggested studies could then be compared and contrasted to the present study findings to further our understanding of how nurses make a difference to patients and families.

Summary

Chapter Five has included a brief summary of the findings and presented limitations of the research. The discussion section has compared and contrasted existing literature concerning how nurses make a difference and the invisibility of nurses' work to the study findings; has shown how nurses' values implicit in the study are similar to other researchers' findings; and has illuminated the important roles of family members and how nurses support those roles in the present study and in the existing literature. Finally, implications for nursing practice, education, and further research were discussed.
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Appendix D: Nurses’ perceptions of the difference their nursing practice makes in the lives of patients and families.

Demographic Data

Participant #: __________
Date: _________________

Position Held: ____________________________

Gender (circle one): Male Female

In what year were you born? _________________________

Educational Background (tick all that apply):

___ Diploma in Nursing
___ Bachelor’s Degree in Nursing
___ Master’s Degree in Nursing
___ PhD in Nursing

Clinical Area of Practice: _______________________

Total Years of Practice: ______   Years in Current Position: ______

Current Employment Status:

___ Casual
___ Part-time
___ Full-time

Site of Employment: _____________________________
Appendix E: Nurses’ perceptions of the difference their nursing practice makes in the lives of patients and families.

Research Synopsis

The goal of this research is to obtain stories from nurses that describe how nursing practice makes a difference to patients and families. The stories may describe “big” things nurses do to make a difference and/or may describe the day-to-day practices and “little” things nurses do to make a difference. I wish to learn about your experiences in making a difference to patients and families, especially about nursing practices that are not common knowledge or may be invisible to the public. It is hoped that your stories along with others will help illustrate the importance of the work of nurses to the ongoing health status of patients and families. The findings from this research will help describe nurses’ work to other health care professionals and the general public.
Appendix F: Nurses’ perceptions of the difference their nursing practice makes in the lives of patients and families.

Guiding Questions

1. Tell me about a specific time or situation where the things you did as a nurse that are not common knowledge or easily seen made an important difference in the lives of patients and families. OR Tell me a story that would reveal aspects of nursing that you think are largely invisible that made a difference in the lives of a patient or family.

2. What did you actually do? If I were there, what would I have seen?

3. What kinds of factors influenced your ability to make a difference in this situation?

4. What enhanced your ability to make a difference in this situation? What things made it more difficult?

5. How did you know you made a difference?

6. How long ago did this happen? How did your work environment support or limit you in doing this for your patients?

7. You have told me a story about the ways you went out of your way to make a difference to your patients. I would now like to hear about how the small things that nurses do make a difference. Can you tell me a story of how in your routine day-to-day work you made a difference to a patient?

Prompts

1. Could you explain that a little more please? (or) Tell me more about that.

2. What enabled you to do that?

3. What prevented you from doing that?
4. Can you remember another situation involving a patient and/or his family where your nursing practice made a difference to their lives that is different in some way from the last story you told me? Can you explain in a story what you did?

Ending the Interview

1. Is there anything else you would like to tell me?

2. Is there anything you would like to ask me?
Appendix G: Nurses' perceptions of the difference their nursing practice makes in the lives of patients and families.

Synopsis of Nurse Participants

RN #1

RN #1 worked as a nurse for 24 years of which at least 17 years have been in the intensive care unit (ICU). She agreed to be interviewed in her home while sharing a pot of tea. She was very eager to provide many stories and was careful to recall events accurately. The majority of the 12 stories she shared revealed that she did make a difference to patients and families even though she did not always feel that way at the time. RN #1 often downplayed her expertise and specialized knowledge. One of the most important ways that RN #1 made a difference to patients and families was by going the extra mile. These stories focused on her efforts in making the hospital experience as positive as possible for patients and families. RN #1 stated that she used her own personal experience of having a relative in a critical care unit to imagine what others were going through.

RN #1 focused on the routine nature of her nursing practice and was able to recall stories that illustrated how that practice sometimes made profound differences to patients. One of the most unusual stories she shared was about witnessing an arrest and providing defibrillation to a patient, thereby saving his life. This story is quoted in Chapter Four. She considered this action part of her routine care!

RN #1 also stressed how important it was to develop positive relationships with patients and families, and how those relationships enabled her to effectively meet patient and family needs. When telling these stories, RN #1 was very enthusiastic and emphasized the honor she felt in caring for the patients and families involved. RN #1 was very conscious of how her
patients looked to their family members and she tried to keep the physical layout of the room clean and tidy. It was evident that RN #1 considered herself part of the nursing and health care teams and used this structure to provide quality nursing care. The following excerpt of a story RN #1 shared represents her overall feelings about working in the ICU:

I think that in my opinion anyway, that’s one of the best things about working in Intensive Care because I have one patient. But I, certainly that one patient can take all of my attention and all of my time but, that also means I have one family that I can focus on and give my attention to and my time to. So, to me, that’s one of the best things in ICU, that’s one of the things that I appreciate. I found on the ward I never really got to know families as well as I do in ICU because I had, I don’t know how many patients I had, eight or ten or whatever, and yeah, my time with family was very limited whereas, in ICU I’m there beside that patient for twelve hours. And whenever that family is there, I’m there beside them! So a lot more intense I think, our relationship but, yeah, to have that time, to have that time to be able to get to know them and to hopefully make a difference [laughs].

RN #2

RN #2 preferred to be interviewed in her home on her day off from work. Even though she was busy preparing for her upcoming wedding and a future move to another home, she made time for the interview. She felt that this research study was important. RN #2 had been a nurse for 12 years, the majority spent working as an operating room nurse. She had less than a year’s experience as a critical care nurse. She stated she felt herself a novice in the critical care area but was able to draw upon her expertise as an operating room nurse. She revealed that when
working in the OR, she constantly updated herself on new procedures and always liked to be prepared. She was a resource for other nurses, surgeons, and anesthetists.

One of the things RN #2 stressed in the majority of her 7 stories was to think ahead and be prepared. She knew her nursing practice benefited patients and families and was very proud to be able to make a difference. She was a team player and believed good communication resulted in nursing care for patients and families that made a difference. Many of her stories involved advocating for her patients and families. These stories revealed her conviction and foresight. The following quote represents the importance RN #2 placed on providing patients and families with accurate information and allowing them some control over their care. This excerpt represents a typical story shared by RN #2:

I really made a difference one day and I made a difference to the family too. I had a patient who was in congestive heart failure awaiting a transplant. I introduced myself as an RN, experienced RN from the operating room and his eyes lit up. He says, “You know all about it then” and I said, “Yeah, I do.” So basically I said, “Well, I can tell you as much as you want to know or as little as you want to know” and he said he wanted to know the whole thing. I spent an hour with him and basically, I took him through the whole process.... And I told him about my previous experiences with patients.... I said it’s very emotional.... So I felt that I really empowered him. And it was empowering for myself because as an OR nurse it’s been a long time since I’ve been at the bedside and I felt that this is what I could offer this guy; is [sic] my knowledge.

RN #3

RN #3 had 22 years experience as a nurse and has worked at least 8 years in the Perianesthetic Care Unit and Stepdown Unit, which were located side-by-side. She agreed to
meet me in a hospital library on her day off. Over a cup of coffee, RN #3 shared 10 stories that focused on providing the best nursing care possible. She treats patients and families how she would like to be treated if she were hospitalized and uses intuition to support her practice. Phrases that represent her views in the stories include “just part of my job,” “takes her expertise for granted,” and “I just do it.” She also believes that families are very important and that teamwork is essential in critical care areas.

RN #3 revealed her belief in keeping patients and families informed; attending to their physical, emotional, psychological, and cultural needs; advocating for them; and bending the rules when necessary. A number of stories were about her commitment to nursing and how she often worked overtime to accommodate the unit and benefit patients and families. RN #3 was very concerned about staffing and nursing issues. The following story is typical of the stories shared by RN #3:

I felt that I made a difference for the patients [by working overtime]. Yes, because there was only one nurse on and at that time when I was asked if I could do it because there were no nurses available with that. It was a ventilated case and then after I had said “yes” there was another patient that came out. A ventilated again: a very, very sick patient. So there was [sic] only two of us. So I was, I was tired, but I felt very, well I felt sad for the nurse who would have been by herself first of all, because you do need two nurses. At least three nurses if you’ve got two vents in order to give proper care because anything could go wrong. Anything could go sour during the, you know, these are sick patients. [I made a difference because] I was able to take a vent first of all. And look after this person with whatever energy I had left [light laughter]. So I coped with that. I felt that I, although I was tired, I was sort of trying to keep alert and monitoring
the patient. At least he was looked after on a one-to-one basis and we did get a break. Somebody did come around from next door and did give us a break which was you know, whatever break we got we took which helped. But I think on a one-to-one basis I was able to at least turn the patient, I was able to do his feeding, I was able to make sure that he was you know, getting the correct medication, his vital signs were observed you know, monitoring. I was able to do all that. Because otherwise it would have been a two to one and it’s not fair for the patient. I do feel that’s unfair.

RN #4

RN #4 had 26 years of nursing experience of which at least 10 were spent working in the Perianesthetic Care Unit and Stepdown Unit. At the time of the interview, she had a dual role as Clinical Nurse Leader and staff nurse. She agreed to be interviewed in a hospital library on her day off. Of the seven stories she shared, RN #4 often minimized her role in attaining positive events and emphasized the routine nature of her work. She did accentuate the importance of teamwork, good communication, holistic care, and how her nursing attitude of helping others extends outside the workplace. Her stories emphasized how she tries to give patients whatever they need. She also embodied herself as a hard working and devoted nurse. Three of the most important ways that RN #4 believed she made a difference were to advocate assertively for her patients and families, to imagine what it was like for them, and to constantly anticipate what patients and families may need. She stated she was shocked whenever her work was acknowledged as special.

The following quote summarizes how RN #4 tries very hard to deal with numerous patient and family challenges and reflects some of the pressures she feels in being a critical care nurse:
Like you know you’re thinking, “Well, I’m trying to discharge this [street] patient but where are you going to discharge him to.” You know. Very big surgeries, you know, day care maybe but you wonder. You think, well, your orders say discharge and all you have to do is discharge him back to day care and go home, right? But when you start thinking well, where is this person going to go, what’s he going to do, you know? So I think in knowing, looking ahead at these types of scenarios, getting social work on, and finding out if there’s somebody available to look after him - even a street buddy - and I think that’s come across a few times, you know. And I’m thinking of the drug addict mommy who’s just had a baby, you know. You start thinking but you try not to too much but [laughter]. You think, what’s going to happen to the baby you know? And you try to look ahead. I’m a great one for looking ahead and thinking you know. So those types of things bothers [sic] me a little bit more, you know. But I think just in those regards, you can make a difference you know?

RN #7

RN #7 had 15 years nursing experience of which at least 12 years were spent working in ICU/CCU/Cath Lab. She agreed to be interviewed at work during an extended break. This interview was the longest and one of the most interesting because RN #7 was very reflective of her nursing practice and had a lot of knowledge to share. Some of the ways RN #7 made a difference to patients and families was through developing emotional connections and positive relationships, providing unlimited family support, advocating for patients and families, working as a team member, being passionate, and constantly upgrading herself. At the time of the interview, RN #7 worked in dual roles as a staff nurse and Clinical Nurse Leader of the CCU.
She appreciated her role as a mentor and revealed in her stories that she also uses others to guide her practice.

Her stories were told with great passion, understanding, insight, acceptance, and kindness. The following quote is representative of her stories:

Well I think as ICU nurses we have, we're very much the workers in the trenches. We're often the person of initial contact with the family. And whether we're the primary care nurse or the nurse who's able to step out to the waiting room to establish contact, I think that the tone that we use, the manner that we use, the information we give is, has a huge impact on families. I think I see that again and again. How we can set the tone for the entire hospitalization stay of that family. And I've seen great successes and I've seen just shameful failures as well. And I think what I have learned what works is that you need to make it a priority. That stepping out of that, those locked doors to establish a rapport with the family is an absolute priority. And if I cannot do it as a bedside nurse I will delegate somebody of my choice, who I know will use the kind of approach that I would be comfortable with. So I actually take a very proactive role in deciding who's going to go out there and sometimes, often the Clinical Nurse Leader is a good choice, but sometimes I feel it may not be. So, I just want to make sure that that initial contact is a good one and then my second priority is to get the family in as soon as possible. And so, when I try to think back in my practice as to how I influence that, I think, I see my role as a bedside ICU nurse as one of patient advocate. And there are times when the medical system clashes with that ability to advocate for the patient. And I've had to become, I think over the years more comfortably assertive in making sure that the family is spoken to and spoken to by physicians who have a - not only know what they're saying, which is
not always the case and because we deal with a teaching hospital here, sometimes you take your changes with some of the residents - but also in a manner that, that answers their questions.

*RN #8*

RN #8 agreed to be interviewed during her lunch break at work. This was a difficult interview because she had to eat and talk in a short period of time. Nevertheless, the interview yielded six stories. RN #8 had 15 years nursing experience of which at least 9 years were in the ICU. She had recently changed from part-time to casual status and had some difficulty thinking of stories that represented how she made a difference to patients and families. She believed nursing is invisible and frequently took her own nursing practice abilities for granted.

RN #8 felt her nursing practice did benefit patients and families though, even when she was performing routine care. Typical of her stories was her desire to treat others, as she would like to be treated if hospitalized. She displayed empathy for unconscious patients, emphasized the importance of anticipatory guidance, and focused on decreasing patient and family stress and anxiety. She believed the better the relationship between the nurse, patient, and family was, the better the outcome and the less overall anxiety. Her personal experience with having a loved one in ICU helped her provide care that made a difference. Her stories emphasized the importance of teamwork.

The following quote from one of RN #8’s stories answers a question about the invisible things she did that benefits patients and families. Her story reflected insight into some of the things she has learned over the years as a critical care nurse:

> Probably a lot of it is probably non-verbal. Just staying in the room, holding their hands. I mean it just sounds so trivial but, just being there with them and not saying anything. I
think over the years I've realized the less you say the better. I don't know what it is. [Laughter] You know. Just kind of stay there with them. They might not even know they need you. I was just going to say, that's probably what a lot of nurses are so obsessed with. Giving their patients baths and our patients, in this unit, are probably cleaner than clean, you know. [Laughter] And probably that's a way that we do try to make a difference for those unconscious people. That just keeping them – we just think that, “Oh, you know if I was here I’d want to have a bath. I’d want to be comfortable.” You know what it’s like to be home, sick in bed and you’re sweating and you’re not, you can’t move or whatever. You feel achy so doing those little things sure makes a difference.

RN #9

RN #9 agreed to be interviewed at work during a break. At the time of the interview, she had 18 years of nursing experience of which at least 13 were in the ICU. In telling her seven stories, RN #9 depicted herself as a nurse that was able to adjust her behavior to provide competent care to people of various personalities, displaying a range of emotional behaviors, and during diverse situations. Many of her stories were about supporting dying patients and grieving families. She admitted to advocating for dignified deaths and told of moral dilemmas involving advanced technology and keeping patients alive. She believed the ICU nurses are the experts concerning patient and family needs and shared a number of stories where she assertively advocated for those needs.

RN #9 spoke of the importance of positive relationships and acting as a partner in patient care. She always ensured patient comfort and was sensitive to the needs of family members, however subtle. It was evident in her stories that she treated patients and family members as
fellow human beings and did whatever she could to help them endure the hospital experience.
She often attributed that teamwork enabled her to make a difference. The following quote
represents a typical story shared by RN #9:

Well, I always feel like if someone has to have a family member in here that my
you know my sister-in-law often says, “But they die sometimes.” And I say, “Yeah, but
if I can make it the best it can be in that awful situation then I’ve done my job.” So that’s
sort of my goal. So if I can’t do anything about the situation that the person’s found them
self in, all I can do is, affect how their perception of how the patient’s cared for while
they’re in here. So that’s my, it’s something that I have to manage for myself. That if I
can make it the best death or the best, you know life while they’re in there and take care
of their patient, his needs and his medical problems as well as his comfort, that that’s
what my goal is. And I think a lot of nurses here are very aware of the patient’s comfort
and whether they’re suffering or not because they do some horrible things here. But
people are usually quite aware whether the patient’s comfortable while we do it.
‘Cause if they’re going to die in the end, we don’t want to put them through awful times.

RN #10

RN #10 had been a critical care nurse for one and a half years. She had previous
experience working in a burn unit in the United States. Although she was the youngest RN
interviewed, she presented herself as a competent and knowledgeable nurse who was interested
in continually improving her nursing practice. During a break at her work during night shift, RN
#10 shared 7 stories about how her nursing practice benefited patients and families. She
described herself as an open and social person who enjoyed “getting to know” others. Her
stories illustrated how making positive relationships with patients and family members enabled
her to make a difference. She treated patients how she would want to be treated and emphasized the importance of teamwork.

RN #10 shared stories in which she made herself available to patients and families. Some of her priorities in caring for patients included ensuring pain control and decreasing stress and anxiety. She enjoyed talking with patients and families and appeared comfortable in teaching others. She strongly believed in dignified deaths and often advocated for DNR (do not resuscitate) directives. In comparing working in the United States to working in British Columbia, RN #10 stressed the importance of adequate staffing to provide quality nursing care, something that was lacking in her previous job. In her stories, she presented herself as a genuine and empathetic person who enjoyed working as a nurse. The following quote represents a typical story shared by RN #10:

When I think back to North Carolina we had this one woman who was 38 years old and a mother of three. She had self-inflicted her burns and wasn’t going to make it. And was not a DNR. Very sick, bleeding out and we were just prolonging the inevitable. We had really strict rules about visiting hours, guidelines, who could come at what age and, when her family came, she had children who were not of the proper age to come back to the burn unit. So they were not going to be allowed to see their mother before she passed. The rules of the unit had been stated and also she looked desperate. So it was a fine line. But with the help of the chaplain and I think that entire 12-hour shift, I spent with the family, we talked with the kids, we explained to them and we went through the policies to be able to get one of the little girls who wanted to go back to be able to see her Mom; she was able to go back and say good-bye. That made a big difference because it gave closure to the family.
RN #11

RN #11 agreed to be interviewed during one of her breaks on a night shift. She shared 10 stories. At the time, she had worked as a nurse for 21 years of which at least five years were in the ICU where she was interviewed. RN #11 felt strongly about “giving the patient and family whatever they need.” In one story she revealed that she makes the biggest difference to patients and families when the patient is dying because “there’s not a whole lot of medical care going on but there’s a lot of nursing care going on.” Even though some of RN #11’s stories involved emotional detachment, RN #11 explained how emotional connections allows her to make the most difference. At least three stories revealed RN #11 to be an assertive nurse, yet she denied feeling this way. Regardless, RN #11 presented herself as a patient and family advocate and believed that she was able to benefit patients and families through advocacy.

RN #11 often exclaimed, “It’s my job” and downplayed her role in benefiting patients and families. She often spoke of the teams involved in making a difference. RN #11 told stories about providing psychological and spiritual support and instilling hope. She valued positive communication with patients and families. The following quote represents how RN #11 benefits patients by advocating for them and providing good physical care:

I’m big on skin care. You know. We wash our patients far too much and we just dry their skin out. People don’t do a lot of good skin care. I like to do a lot of skin care you know, do their feet and make sure, ‘cause they get all dry and scaly and they get itchy. [P] I don’t know. I always like to have music. If I know my patient really likes music. We had a patient recently who was in here for a long time and he liked the Chinese radio station and a lot of people didn’t like to be in the room with a Chinese radio station going on because it was annoying to them but it didn’t bother me at all. And I would put it on
all the time for him and make sure he could hear it or the TV. I couldn’t imagine lying in bed and doing nothing but listening to either the nurses or the machines. I always think that there should be some sort of background music and we don’t have enough of it. Or you end up with either battle of the bands where you have one radio over here and one radio there or you have the music that the nurse likes to listen to.

**RN #12**

RN #12 agreed to be interviewed during work hours. At the time, she had a student that was able to care for her patient but RN #12 had to be close-by in case she was needed. RN #12 had 20 years nursing experience of which at least 15 years were as a critical care nurse working in ICU. She also worked as a casual Clinical Coordinator at the time of the interview.

RN #12 said she loved her job and was very passionate and enthusiastic to tell her stories. She stated that because she balances her life, she avoids “burnout.” Of the nine stories shared, developing emotional connections was the primary way RN #12 made a difference. But if emotional connections were absent due to various circumstances, she was also able to provide a high standard of care. RN #12 spoke with conviction about treating others, as she would want to be treated. She imagined patients and family members as her loved ones. She stressed the importance of involving family, providing accurate information, and providing anticipatory guidance. She often exclaimed, “it’s my job,” “it’s common now,” and “it’s usual nursing care.”

RN #12 believed strongly in being assertive and advocating for her patients and their families. She was very aware of the political issues in health care and had strong opinions concerning them. She depended on teamwork to make a difference, liked to give patients choices when possible, and strived to provide holistic care. She highlighted that positive feedback meant everything to her and made her job worthwhile. The following quote is an
example of her stories and showed how assertive RN #12 could be. The story is about an elderly woman who was dying and a resident that wanted to practice inserting a swan-ganz catheter:

What really bugged me at the time was that they just, you know, informed the nurse that they’re going to insert a swan, ‘cause inserting a swan is that you have to prepare this and all these lines and stuff like that. And it’s just like dictatorship, “I’m going to insert a swan.” And I said, “No, you’re not.” And, “sorry, you’re not.” And so, “Well, I’m going to insert one.” And I said, “Hold on. You’re not inserting a swan because this and that and this and that.” And I went up higher. I went to the fellow and said, “Why are we inserting a swan?” And, “Well, we really don’t have to but you know.” Yeah, it’s a practicing hospital. So I think and I said, “No, that’s not, that’s not right because that’s my therapy. I don’t want you touching.” I don’t know, he is practicing somewhere else, but not on this person because this patient’s dying. Yeah. So an older woman, an elderly woman, I mean you know. So, A: ah, I think that’s one of the number one asset that the ICU nurses have is assertiveness. Yeah.

RN #13

RN #13 agreed to be interviewed at work during a coffee break. She had 23 years nursing experience of which at least 18 years were as a critical care nurse working in the ICU. She had past experience as a psychiatric nurse and was very knowledgeable about patient and family psychological, spiritual, religious, and emotional needs. Throughout the eight stories shared, RN #13 revealed her concern for the families after a loved one died. She felt strongly that families suffer from post-traumatic stress syndrome and believed that they needed further support but did not receive it once they left the hospital. She identified the need for further research in this area and wished the province would fund more family counselors for these
circumstances. The following excerpt summarizes the strong feelings RN #13 had about bereaved families and was part of the last story shared in the interview:

You know what? I think you should advocate for a family counselor. In ICU. In an ICU unit. Or actually I think someone should study the crisis. The kind of crisis that people, families are in here and to acknowledge it. To put a term to it and to put a treatment to it. To have something in there because I don’t think people realize what families go through for a prolonged period of time. Yeah, you know. They don’t have it in the system. They don’t acknowledge it right now. I doubt there’s been enough studies to say exactly the kind of level of crisis that people are in first and to see how it affects them. It affects their whole life. They get PTSD [post-traumatic stress disorder] symptoms you know. They, and it changes their whole life because and their whole life stops. And their jobs stop often times. They can’t work: they can’t function. Everything, and nobody acknowledges this is happening. And there’s no, if they had one counselor or a person that’s just devoted to helping families, they would get more consistency, they’d debrief better, they would have, you know, not so many different, varied opinions by the nurses, like they’re all getting slightly different side from every nurse. And all that.

RN #13 believed she made the most difference when she was able to make a positive connection with patients and families. She valued patience in caring for critically ill people and treated them as she wished to be treated if she were hospitalized. RN #13 was very sensitive to decreasing stress and anxiety levels by providing information, listening, having a positive attitude, being authentic, and advocating. She spoke often in her stories about patients and family members feeling like objects and how she benefits them by treating them as people and
maintaining their dignity. She also acknowledged that teamwork enables her to benefit patients and families.

**RN #14**

RN #14 was a very energetic critical care nurse who was devoted to his work. He claimed he worked constantly. At the time of the interview, he had been a nurse for 19 years mainly in critical care areas. He stated he had worked one year in the CCU in which the interview took place in dual roles as staff nurse and Clinical Nurse Leader. He agreed to be interviewed before his night shift began but ended up working early so talked with me during a break.

RN #14 felt strongly about providing psychological and spiritual support to his patients and families. He had a very open-minded attitude and did whatever he could to meet patients'/families' needs. He felt that developing emotional connections enabled him to make a difference and believed in including the family (whoever the patient identified as family) in the patient's care. He took his ability to provide a high standard of nursing care for granted.

Typical themes in the 11 stories shared were instilling a sense of hope, developing trust, using touch, being accessible, maintaining patient/family dignity, and working as a team member to benefit patients and families. He always treated others, as he would want to be treated and strived to make the hospital experience as positive as possible. RN #14 paid attention to detail and used empathy and intuition to guide his care and make a difference. RN #14 never hesitated to do whatever he could to benefit patients and families as revealed in the following quote:

We had a lady here at, in the spring, in June it was and she had, she initially came in and she was throwing up clots everywhere to her brain. She had a stroke. Throwing up clots to her leg. She was throwing up clots everywhere. And we were aggressive with her for
about a week. And then we decided that now we’re going to palliative. And so this was another lady that who loved gardens, and the roof garden [located on top of the hospital] with the beautiful view, and the rhododendrons up there, and just the beautiful colors. So with the family, again, we arranged this patient to go up and have a rooftop visit. And it was very hard to tell how the patient responded because they were severely compromised with the stroke, aphasic, so it’s very hard to measure the outcome in terms of what it did for that patient. We’re hoping that it, that our goal was pleasing the patient. We certainly know that it meant a lot to the family. Because they knew how much Mom loved her garden. And she loved her flowers. And you know, and you know, just including Mom in, you know, like life is continuing today, you know. Today we are enjoying the flowers, you know. You’ve given us that gift so sharing that with this family. They were happy. You could see that they were sharing. Flowers, the moment with that family, you know because Mom loved it and how it was passed on to the daughters, the son and the husband and you could see that they all came together on that common theme. So it was just, it was just visible by their enthusiasm and they were happy about it and they were thankful again. Quite often I find that there’s a patient’s family, whatever, will acknowledge things that are important to them. Say things that are remarkably important to them. They were very thankful for that.