PROGRESSIVELY ENGAGING: HOW NURSES, PATIENTS AND FAMILY MEMBERS MANAGE RELATIONSHIPS IN ACUTE CARE HOSPITAL SETTINGS

by

CHERYL ANN SEGARIC

B.Sc.N., The University of Windsor, 1983
M.ed., Simon Fraser University, 1993

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in

THE FACULTY OF GRADUATE STUDIES

(Nursing)

THE UNIVERSITY OF BRITISH COLUMBIA

August 2007

© Cheryl Ann Segaric, 2007
ABSTRACT

This grounded theory study, informed by symbolic interactionism, explains how nurses, patients, and family members manage relationships in order to plan and provide care in acute care hospital settings. The study also explains the effects of contextual and systemic features associated with acute care environments and participants' personal characteristics on their efforts to manage relationships. Data collection included thirty three hours of participant observation and forty interviews. Seventeen interviews were conducted with nurses, ten with family members, and thirteen with patients. Participants were recruited from a total of ten acute care units across four community hospitals in the Fraser Health Authority of British Columbia; there were four medical units, three surgical units, two transitory care or activation units, and one community hospital intensive care unit.

I constructed the basic social psychological process of progressively engaging. The process describes how nurses, patients, and family members manage their relationships during patient care by developing varying levels of engagement. The levels of engagement are represented by three stages, including: focusing on tasks, getting acquainted, and building rapport. Structural conditions and personal factors, relevant to nurses, patients, and family members, facilitate or constrain their efforts to progressively engage by contributing to or detracting from their shared perspectives. Levels of engagement ranged from 'just doing the job' to 'doing the job with heart' or making a deep human connection. Higher levels of engagement achieved in nurse, patient, and family member relationships correspond with more satisfaction expressed by participants about their relationships and nursing care. The substantive theory of progressively engaging makes a significant contribution to the family nursing theory. The process has implications for nursing education, practice, research, and administration.
## TABLE OF CONTENTS

Abstract.............................................................................................................. ii

Table of Contents.................................................................................................. iii

List of Tables......................................................................................................... viii

List of Figures......................................................................................................... ix

Acknowledgements............................................................................................... x

Dedication............................................................................................................... xi

1 Introduction......................................................................................................... 1

1.1 Background.................................................................................................. 1
1.2 Significance.................................................................................................. 3
1.3 Statement of Problem.................................................................................. 5
1.4 Statement of Purpose.................................................................................. 6
1.5 Research Questions..................................................................................... 7
1.6 Conceptual Definitions.............................................................................. 7
  1.6.1 Family................................................................................................. 7
  1.6.2 Acute care.......................................................................................... 8
1.7 Overview of Chapters................................................................................. 8

2 Literature Review............................................................................................... 9

2.1 Issues Related to Language.......................................................................... 10
  2.1.1 Lack of a common language............................................................... 10
  2.1.2 Theory to practice gap................................................................. 11
  2.1.3 Family as context........................................................................... 12
  2.1.4 Family as unit................................................................................ 13
  2.1.5 Family system............................................................................... 14
  2.1.6 The need for conceptual clarity..................................................... 16
2.2 Issues Related to Contextual Features...................................................... 18
  2.2.1 Failure to account for the work environment............................... 19
  2.2.2 Lack of nursing time.................................................................... 21
  2.2.3 Implications of time for nurse-family relationships................... 23
  2.2.4 Other contextual issues affecting nurse-family interaction.......... 25
2.3 Issues Related to Interactive Processes.................................................. 28
2.4 Summary.................................................................................................... 36
TABLE OF CONTENTS continued.

3  Theoretical Framework: Symbolic Interactionism ................................................. 37
   3.1 An Overview of Symbolic Interactionism ......................................................... 38
   3.2 Pragmatism ................................................................................................. 39
   3.3 Ontology ........................................................................................................ 41
   3.4 Epistemology ................................................................................................ 45
   3.5 Methodology .................................................................................................. 50
   3.6 Summary ....................................................................................................... 54

4  Strategy of Inquiry: Grounded Theory ................................................................. 56
   4.1 Grounded Theory as Informed by Symbolic Interactionism ............................ 56
   4.2 Grounded Theory – An Overview ................................................................. 58
   4.3 Research Design .......................................................................................... 61
      4.3.1 Purpose .................................................................................................... 61
      4.3.2 Questions ............................................................................................... 62
      4.3.3 Initial purposive sampling ..................................................................... 63
      4.3.4 Inclusion/exclusion criteria for patient participants .............................. 65
      4.3.5 Inclusion/exclusion criteria for nurse participants ............................... 66
      4.3.6 Inclusion/exclusion criteria for family member participants ............... 67
   4.4 Ethical Considerations ................................................................................... 67
      4.4.1 Obtaining ethical approval ..................................................................... 69
      4.4.2 Ethical approval extension ..................................................................... 70
   4.5 Procedures ..................................................................................................... 70
      4.5.1 Negotiating access .................................................................................. 70
      4.5.2 Participant recruitment strategies ......................................................... 71
      4.5.3 Data collection ....................................................................................... 73
      4.5.4 Descriptive data .................................................................................... 74
      4.5.5 Semi-structured interviews .................................................................. 75
      4.5.6 Audio-taping ......................................................................................... 77
      4.5.7 Participant observation ......................................................................... 79
      4.5.8 Field notes ............................................................................................. 82
      4.5.9 Personal journal .................................................................................... 84
   4.6 Data Analysis .................................................................................................. 85
      4.6.1 Open coding ............................................................................................ 86
      4.6.2 Selective coding for a core category ..................................................... 91
      4.6.3 Core category ......................................................................................... 93
      4.6.4 Theoretical coding and sorting .............................................................. 94
      4.6.5 Saturation and completeness ................................................................ 95
   4.7 Criteria for Rigor ............................................................................................ 97
   4.8 Limitations ...................................................................................................... 103
   4.9 Summary ....................................................................................................... 104
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Sample</td>
<td>106</td>
</tr>
<tr>
<td>5.1.1</td>
<td>Description of patient participants</td>
<td>106</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Description of nurse participants</td>
<td>108</td>
</tr>
<tr>
<td>5.1.3</td>
<td>Description of family member participants</td>
<td>110</td>
</tr>
<tr>
<td>5.2</td>
<td>Progressively Engaging: Theoretical Overview</td>
<td>112</td>
</tr>
<tr>
<td>5.3</td>
<td>Stages of Engaging</td>
<td>114</td>
</tr>
<tr>
<td>5.3.1</td>
<td>Stage one: Focusing on tasks</td>
<td>116</td>
</tr>
<tr>
<td>5.3.2</td>
<td>Stage two: Getting acquainted</td>
<td>119</td>
</tr>
<tr>
<td>5.3.3</td>
<td>Stage three: Establishing rapport</td>
<td>120</td>
</tr>
<tr>
<td>5.4</td>
<td>Grounded Theory: The Progressively Engaging Process</td>
<td>121</td>
</tr>
<tr>
<td>5.4.1</td>
<td>Stage one: Focusing on tasks</td>
<td>121</td>
</tr>
<tr>
<td>5.4.2</td>
<td>Structural conditions and personal factors</td>
<td>122</td>
</tr>
<tr>
<td>5.4.3</td>
<td>Terms of engagement</td>
<td>124</td>
</tr>
<tr>
<td>5.4.4</td>
<td>Perception of time</td>
<td>126</td>
</tr>
<tr>
<td>5.4.5</td>
<td>Language barriers</td>
<td>128</td>
</tr>
<tr>
<td>5.4.6</td>
<td>Patient/family cooperation/compliance</td>
<td>130</td>
</tr>
<tr>
<td>5.5</td>
<td>Interpersonal Dynamics</td>
<td>131</td>
</tr>
<tr>
<td>5.5.1</td>
<td>Positive interpersonal dynamics</td>
<td>132</td>
</tr>
<tr>
<td>5.5.2</td>
<td>Negative interpersonal dynamics</td>
<td>134</td>
</tr>
<tr>
<td>5.6</td>
<td>Falling Through the Cracks</td>
<td>138</td>
</tr>
<tr>
<td>5.6</td>
<td>Feeling Each Other Out</td>
<td>143</td>
</tr>
<tr>
<td>5.7</td>
<td>Stepping Back</td>
<td>145</td>
</tr>
<tr>
<td>5.8</td>
<td>Just Doing the Job as Outcome</td>
<td>150</td>
</tr>
<tr>
<td>5.9</td>
<td>Section Summary</td>
<td>153</td>
</tr>
<tr>
<td>5.10</td>
<td>Stage Two: Getting Acquainted</td>
<td>154</td>
</tr>
<tr>
<td>5.10.1</td>
<td>Terms of engagement: Business</td>
<td>156</td>
</tr>
<tr>
<td>5.10.2</td>
<td>Terms of engagement: Acuity</td>
<td>158</td>
</tr>
<tr>
<td>5.10.3</td>
<td>Terms of engagement: Continuity of care</td>
<td>161</td>
</tr>
<tr>
<td>5.10.4</td>
<td>Terms of engagement: Family involvement</td>
<td>163</td>
</tr>
<tr>
<td>5.10.5</td>
<td>Terms of engagement: Friendliness</td>
<td>165</td>
</tr>
<tr>
<td>5.10.6</td>
<td>Terms of engagement: Positive interpersonal dynamics</td>
<td>166</td>
</tr>
<tr>
<td>5.10.7</td>
<td>Terms of engagement: Questions</td>
<td>168</td>
</tr>
<tr>
<td>5.10.8</td>
<td>Terms of engagement: Personal sharing</td>
<td>171</td>
</tr>
<tr>
<td>5.10.9</td>
<td>Terms of engagement: Cooperative/compliant patients and families</td>
<td>174</td>
</tr>
<tr>
<td>5.10.10</td>
<td>Terms of engagement: Negative interpersonal dynamics and stepping back</td>
<td>174</td>
</tr>
<tr>
<td>5.11</td>
<td>Section Summary</td>
<td>177</td>
</tr>
<tr>
<td>5.12</td>
<td>Stage three: Establishing Rapport</td>
<td>178</td>
</tr>
<tr>
<td>5.12.1</td>
<td>Respect, trust, and reciprocity</td>
<td>179</td>
</tr>
<tr>
<td>5.12.2</td>
<td>Interpersonal dynamics</td>
<td>180</td>
</tr>
<tr>
<td>5.12.3</td>
<td>Stepping back</td>
<td>187</td>
</tr>
<tr>
<td>5.12.4</td>
<td>Doing the job with heart as outcome</td>
<td>188</td>
</tr>
<tr>
<td>5.13</td>
<td>Chapter Summary</td>
<td>191</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>6 Discussion and Implications of the Study Finding</td>
<td>192</td>
<td></td>
</tr>
<tr>
<td>6.1 Progressively Engaging: A Summary</td>
<td>192</td>
<td></td>
</tr>
<tr>
<td>6.2 Progressively Engaging as a Contribution to Nursing Theory</td>
<td>194</td>
<td></td>
</tr>
<tr>
<td>6.3 Methodological Contribution</td>
<td>196</td>
<td></td>
</tr>
<tr>
<td>6.4 Conceptualization of Family</td>
<td>198</td>
<td></td>
</tr>
<tr>
<td>6.4.1 Pragmatism</td>
<td>206</td>
<td></td>
</tr>
<tr>
<td>6.5 Accounting for Systemic and Contextual Features of the Work Environment</td>
<td>208</td>
<td></td>
</tr>
<tr>
<td>6.5.1 Time</td>
<td>210</td>
<td></td>
</tr>
<tr>
<td>6.5.2 Acuity</td>
<td>216</td>
<td></td>
</tr>
<tr>
<td>6.5.3 Increases in casual nursing staff</td>
<td>217</td>
<td></td>
</tr>
<tr>
<td>6.5.4 Influences of structural conditions on personal factors</td>
<td>218</td>
<td></td>
</tr>
<tr>
<td>6.6 Interactive Processes</td>
<td>220</td>
<td></td>
</tr>
<tr>
<td>6.6.1 Fast-tracking</td>
<td>223</td>
<td></td>
</tr>
<tr>
<td>6.6.2 Stepping back</td>
<td>224</td>
<td></td>
</tr>
<tr>
<td>6.6.3 Using questions</td>
<td>226</td>
<td></td>
</tr>
<tr>
<td>6.6.4 Reciprocity</td>
<td>229</td>
<td></td>
</tr>
<tr>
<td>6.6.5 Shared responsibility</td>
<td>233</td>
<td></td>
</tr>
<tr>
<td>6.6.6 Social capital</td>
<td>235</td>
<td></td>
</tr>
<tr>
<td>6.7 Implications</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>6.7.1 Implications for nursing practice</td>
<td>236</td>
<td></td>
</tr>
<tr>
<td>6.7.2 Implications for nursing administration</td>
<td>243</td>
<td></td>
</tr>
<tr>
<td>6.7.3 Implications for nursing education</td>
<td>246</td>
<td></td>
</tr>
<tr>
<td>6.7.4 Implications for nursing research</td>
<td>250</td>
<td></td>
</tr>
<tr>
<td>6.8 Limitations</td>
<td>255</td>
<td></td>
</tr>
<tr>
<td>6.9 Conclusion</td>
<td>256</td>
<td></td>
</tr>
<tr>
<td>6.10 Chapter Summary</td>
<td>257</td>
<td></td>
</tr>
<tr>
<td>Bibliography</td>
<td>258</td>
<td></td>
</tr>
<tr>
<td>Appendices</td>
<td>269</td>
<td></td>
</tr>
<tr>
<td>Appendix A - The University of British Columbia Office of Research Services and Administration Behavioural Research Ethics Board Certificate of Approval</td>
<td>269</td>
<td></td>
</tr>
<tr>
<td>Appendix B - Fraser Health Authority Clinical Investigation Committee Research Approval Letter</td>
<td>271</td>
<td></td>
</tr>
<tr>
<td>Appendix C - South Fraser Health Authority Regional Research Review Committee Research Approval Letter</td>
<td>274</td>
<td></td>
</tr>
<tr>
<td>Appendix D - Fraser Health Authority Clinical Investigation Committee Approval for Extension</td>
<td>277</td>
<td></td>
</tr>
</tbody>
</table>
### TABLE OF CONTENTS continued.

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>Participant Information Letters</td>
<td>279</td>
</tr>
<tr>
<td>F</td>
<td>Consent Forms</td>
<td>288</td>
</tr>
<tr>
<td>G</td>
<td>Demographic Questionnaire for Nurse Participants</td>
<td>297</td>
</tr>
<tr>
<td>H</td>
<td>Demographic Questionnaire for Family Member Participants</td>
<td>300</td>
</tr>
<tr>
<td>I</td>
<td>Demographic Questionnaire for Patient Participants</td>
<td>303</td>
</tr>
<tr>
<td>J</td>
<td>Initial Interview Guide for Use with Nurse Participants</td>
<td>306</td>
</tr>
<tr>
<td>K</td>
<td>Initial Interview Guide for Use with Patient Participants</td>
<td>309</td>
</tr>
<tr>
<td>L</td>
<td>Initial Interview Guide for Use with Family Participants</td>
<td>312</td>
</tr>
<tr>
<td>M</td>
<td>Participant Observation Guide</td>
<td>315</td>
</tr>
<tr>
<td>N</td>
<td>Sample Field Notes and Participant Observation Notes</td>
<td>318</td>
</tr>
<tr>
<td>O</td>
<td>Sample Conceptual Diagrams</td>
<td>328</td>
</tr>
<tr>
<td>P</td>
<td>Sample Memos</td>
<td>334</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1.1 Demographic Characteristics of Patient Participants............................... 107
Table 1.2 Demographic Characteristics of Nurse Participants..................................109
Table 1.3 Demographic Characteristics of Family Member Participants......................111
LIST OF FIGURES

Figure 1.0  Progressively Engaging Process ................................................. 115
Figure 2.0  Stages of Progressively Engaging ............................................. 118
ACKNOWLEDGEMENTS

I would like to thank the nurses, patients, and family members who participated in this study. Without them this study would not have been possible. I would also like to thank the nurse managers, clinical resource nurses, and staff nurses from the participating acute medical and surgical units for supporting my efforts to understand how nurses, patients, and family members manage their relationships in these settings and specifically for their assistance in the recruiting process.

To my supervisory committee members Dr. Angela Henderson and Dr. Carol Jillings: thank you for the extremely insightful comments and feedback you provided at various stages throughout the research process. It has been a pleasure and an honor to have had the opportunity to work with you and learn from you. I very much appreciate the time and effort that you have spent on my behalf as well as your ongoing support and encouragement.

Finally, to my research supervisor Dr. Wendy Hall: words cannot express my gratitude for all that you have done in an effort to assist me throughout the research process. You inspired, encouraged, and supported me in my effort to reach for and ultimately achieve goals far beyond what I ever imagined I could. It has been such an honor and a privilege to work with you. Your dedication to the nursing profession – practice, education, and research is beyond compare and I am proud to call you my mentor. Thank you for everything!
DEDICATION

I dedicate this work to my family: Tony, Craig, and Stephanie Segaric.

The Friend Who Stands By

When trouble comes your soul to try,
You love the friend who just stands by.
Perhaps there's nothing he can do;
The thing is strictly up to you.
For there are troubles all your own,
And paths the soul must tread alone;
Times when love can't smooth the road,
Nor friendship lift the heavy load.

But just to feel you have a friend,
Who will stand by until the end;
Whose sympathy through all endures,
Whose warm handclasp is always yours.
It helps somehow to pull you through,
Although there's nothing he can do;
And so with fervent heart we cry,
"God bless the friend who just stands by"
(author unknown)

It was you, my loving husband and children, who stood by me every step of the way; from beginning to end. I could not have completed this journey without your unwavering support and understanding. I love you with all my heart. Thank you.
CHAPTER ONE

1 Introduction

For the purpose of establishing the sociological perspective for this research study, this chapter begins with a brief overview of some of the key issues confronting the British Columbian health care system, particularly as they relate to the acute care hospital setting. A description of the research questions is also provided. Key terms relevant to the study are defined. Finally, a brief overview of the chapters comprising this dissertation is presented.

1.1 Background

It has been well publicized in recent years that the health care system in British Columbia and nurses in particular are faced unprecedented challenges around providing quality health care to the people of British Columbia (B.C.). Indeed, the B.C. health care system continues to be threatened by such issues as escalating health care costs, changing social demographics, for example an aging population and subsequent changing trends in general health care needs, a declining nursing workforce, and deteriorating working conditions for nurses (Canadian Institute of Health Information, 2002; Select Standing Committee Report on Health, 2001). Since the early 1990s, these various challenges have served as catalysts for an assortment of restructuring and downsizing initiatives across the provincial health care system including acute care bed and hospital closures, an increase in outpatient services, and the reduction of hospital admissions and length of stay. While these actions have yet to be evaluated, the consequences are being felt by nurses within acute care hospital environments in the form of higher in-patient acuity, longer waiting times for diagnostic and treatment interventions, increased difficulty obtaining immediate care, and increased burden of care for family members both in and outside the
hospital (British Columbia Ministry of Health Planning, 2002; Canadian Institute for Health Information, 2002).

The working conditions of nurses have also been affected - especially those nurses practicing in acute care hospitals. The most common concerns include: the burden of heavy patient loads (in terms of both numbers and acuity), the number of non-nursing tasks required of nurses, and the lack of administrative support and leadership. In a qualitative analysis of comments by 2,500 hospital nurses regarding career and workplace, Dunleavy, Shamian and Thomson (2003) noted that nurses are angry and frustrated at a system that seems to have forgotten that health care is about the people. Dunleavy, et al. writes: "...there is growing concern that nurses are reaching a point of overload, where they will no longer be able to put patients first" (p. 25). Ironically, putting patients and their families first is the mandate given nurses across B.C. by the College of Nurses of British Columbia (Professional Standards for Registered Nurses and Nurse Practitioners).

While issues such as increased patient acuity, reduced length of hospital stay, increased numbers of family members in crisis, and increased nursing workloads accentuate the importance of nursing care that includes families in health care delivery, there is evidence that family-oriented nursing care has become more elusive in acute care practice settings. The disparity between the importance of family nursing and its apparent lack of implementation raises several questions around the relationships between the complexities of the contemporary acute care hospital environment and the establishment of collaborative relationships among nurses, patients, and family members. Indeed, an underlying assumption of this research study is that experiences and perceptions associated with various challenges in the system and subsequent
changes in health care policy and delivery of services influence interactive processes among nurses, patients and family members in terms of planning and providing care.

1.2 Significance

While understanding the key challenges affecting the health care system generally and acute care hospitals specifically is important, the reciprocal effects of the health care system and the people it serves must also be considered. With escalating costs prompting the reorganization of health care delivery combined with increased demands for health care services, the role of families in health care has taken on new meaning and significance. Although the family unit has always been recognized as an important resource for promoting and maintaining the health of its members, today’s families are also expected to assume increased responsibility for providing care to ill family members both in hospital and upon discharge (Conway-Giustra, Cowley & Gorin, 2002; Lee & Craft-Rosenberg, 2002; Wright & Leahey, 2000). This expectation comes at a time when contemporary families are experiencing increased complexity in their structure, development, roles, and functions (Friedman, Bowden & Jones, 2003). In the unexpected event of a family member experiencing an acute illness episode, disrupted routines, altered roles, and strain placed on financial and other family resources, secondary to the addition of the family care-giving role, may result (Denham, 2003; Friedman, Bowden & Jones, 2003). As noted by Duhamel (2004) in response to illness of a family member the entire family may be “shaken functionally and emotionally, and the stability of everyday life is threatened” (p. 68). This in turn, may lead to considerable distress within the family and ultimately undermine both the health of the patient and the family (Denham, 2003; Wright & Leahey, 2005).

While there is clear evidence that families are assuming increased responsibility for pre and post-hospital care (Chisholm, 2000), it is less clear how family members are involved in care
provided to kin who are hospitalized for acute illness. Some study findings report extensive involvement by family in patient care, particularly with regard to emotional support and meeting basic physical needs (Astedt-Kurki, Paunonen & Lehti, 1997); however, many studies have found that family participation is minimal or sporadic (Astedt-Kurki, Lehti, Paunonen, & Paavilainen, 1999; Gavaghan & Caroll, 2002; Paavilainen, Seppanen, & Astedt-Kurki, 2001). Several benefits are associated with participation of family in care, for example, better outcomes for patients promoting health of the family in general (Robinson & Wright, 1995; Wright & Leahey, 2000); enhanced feelings of empowerment among patients and families (Allen, 2000; Newton, 2000); diminished feelings of helplessness by patients and families; and improved compliance and earlier hospital discharge (Allen, 2000). The costs of family involvement in patient care can include guilt, fear, worry, tension, anger, frustration, feelings of powerlessness, role conflict, uncertainty about the future, economic burden, negative attitudes towards the condition or illness, lack of confidence in the family’s ability to cope, and impaired health status of family members (Conway-Giustra, Crowley & Gorin, 2002; Fleury & Moore, 1999; Foxall & Gaston-Johansson, 1996; Lee & Craft-Rosenberg, 2002; Yates, 1998). Such effects are more pronounced for those family members who bear the primary burden of informal care giving.

In the face of increased complexity of roles, structures, and functions in the family, secondary to such social trends such as delayed childbearing, aging parents, and dual-earner families, there has been little recognition of shifts in family demographics and roles by society in general and the health care system in particular (Jacobs & Gerson, 2001; Loveland-Cherry, 1996). Shorter hospitalizations for acute illness have contributed to shorter periods of contact for health care providers and patients and families, less time for discharge assessment, and limited negotiation with family members around discharge to home (Robinson and Wright, 1995). Family members,
particularly women and those with few resources and limited expertise, experience more anxiety about their responsibility to care for an acutely ill family member (Denham, 2003; Ward-Griffin & McKeever, 2000). During an acute illness episode, additional family care-giving responsibilities may result in disrupted routines, altered roles, and strain placed on financial and other family resources which may lead to considerable family distress and poorer patient and family member health outcomes (Denham, 2003).

Consideration of the impact of illness on the whole family has directed attention to the need for nurses to expand their focus of care to be more inclusive of family. This has prompted a proliferation in family nursing publications, educational programs, and family nursing research aimed at advancing family theory for practice (Vosburgh & Simpson, 1993). In spite of these efforts, it has been widely observed that only limited progress in the transfer of family nursing theory to clinical nursing practice has occurred. As Duhamel (1995) stated “In too many clinical settings family nursing is almost nonexistent or developing very slowly” (p. 7). More recently, Hanson (2005) argued that “family nursing is fading despite the fact that families continue to be our best resource for health care” (p. 336). This theory-practice gap has been explained by the lack of specific descriptions of nursing practice with families (Bell, 1995), a lack of interface between nursing practice theory and family nursing theory (Vaughan-Cole, 1998), and various contextual factors that reduce nursing time (Wright & Leahey, 2005).

1.3 Statement of Problem

Nurses in British Columbia are mandated to focus nursing care on patients and their families (Professional Standards for Registered Nurses and Nurse Practitioners). This directive is based primarily on extant knowledge and theory related to the reciprocal influence of families’ health/illness status on all family members (Friedman, Bowden & Jones, 2003; Wright &
Numerous barriers to implementation of family theory and to the formation of collaborative relationships among nurses, patients, and family members exist in acute care hospital settings. While barriers and challenges may be contextual and systemic in nature, little is understood about nurse-patient-family relationships as they develop and evolve in contemporary acute practice settings. Many nursing textbooks present family theory and nursing care approaches; however, few nurses have described or explained the interactions between nurses, patients, and families in acute care clinical practice (Vaughan-Cole, 1998). Consequently, the nature and form that family nursing in the acute care setting takes from the various perspectives of nursing, patient, and family is not known.

1.4 Statement of Purpose

The purpose of my dissertation research entitled: Progressively Engaging: How nurses, patients and family members manage relationships in the acute care hospital setting, is to explain how nurses, patients, and family members who come together in acute care hospital settings manage relationships in order to plan and provide care. A secondary purpose is to explain the effects of contextual, systemic and other features associated with the acute care environment on efforts to manage relationships for the purpose of planning and implementing care. Finally, a third purpose is to explain how features associated with the acute illness and hospitalization experience that are of a more personal nature (e.g. beliefs and values), affect efforts to manage relationships among nurses, patients, and families.

It is anticipated that the theory emerging from this study will provide explanations about the unique circumstances in acute care settings that influence nurses’, patients’, and family members’ efforts to manage relationships during the provision of care for patients and their families. The findings are also anticipated to suggest nursing policy and education initiatives
aimed at promoting and supporting nurses’ collaborative relationships with patients and families experiencing acute illness.

1.5 Research Questions

In the context of implementation of family nursing in the acute care setting, the general area of concern associated with this dissertation research is expressed as understanding the process of managing relationships, between nurses, patients, and family member(s). The overall goal is to explain how nurses, patients, and family members manage relationships in order to plan and implement care. The specific research questions are stated as:

1. How do nurses, patients, and family members perceive their management of relationships in order to plan and provide patient care in the acute care hospital setting?
2. How do contextual and systemic features or structural conditions affect nurses’, patients’, and family members’ efforts to manage relationships to plan and provide patient care?
3. How do personal factors affect nurses’, patients’, and family members’ perceptions of their efforts to manage relationships to plan and provide patient care?

1.6 Conceptual Definitions

1.6.1 Family.

For the purpose of this research study, family is broadly defined with a focus on relationships and interactions. Family, therefore, includes two or more persons interacting by virtue of kinship, friendship or shared living space, who may or may not be related by blood or marriage but who are joined by bonds of sharing and emotional closeness (Bell, 1995; Foxall & Gaston-Johansson, 1996; Friedman, Bowden & Jones, 2003). In terms of participation in the study, family members will include those persons identified by the patient as key participants or sources of support in the process of care planning and/or delivery.
1.6.2 Acute care.

For the purpose of this study, acute care is defined as a level of care involving short-term hospitalization for patients experiencing acute illness, injury, or exacerbation of a disease process (Flintoff & Williams, 1998). Patients experiencing acute illness or injury episodes are those that require specialized treatment, medication and coordinated professional assessment and care until such time that their condition is stabilized.

1.7 Overview of Chapters

This chapter identified the sociological perspective or context of the study by providing a brief discussion regarding the background and significance of the phenomenon of interest. A description of the problem, the purpose, the research questions, and definitions of terms used in the study was also provided. Chapter two provides a synthesis of the literature addressing the difficulties and gaps associated with application of family nursing theory to practice. Chapter three describes the theoretical framework used to guide this interpretive research study. Chapter four offers a detailed account of the grounded theory method and procedures for data collection and analysis utilized in this study, as well as rigor and ethical considerations. In chapter five, the study findings are presented including a description of the sample and the theory of progressively engaging – the basic social psychological process which was constructed from the data that describes how nurses, patients, and/or family members manage relationships in the provision of care during acute care hospitalization. Finally, chapter six includes a discussion of the findings, as well as the implications of the study findings for nursing education, practice and family nursing theory development. Recommendations for further research are also considered.
CHAPTER TWO

2 Literature Review

Despite growing recognition of the importance of family in health care and progress in family theory development over the last two decades, transfer of family theory to acute care nursing practice has been limited (Segaric & Hall, 2005). Indeed, in many areas of nursing practice family nursing continues to be what Friedman, Bowden and Jones (2003) referred to as a "stated ideal rather than a prevailing practice" (p. 42). Central to this problem is the gap that exists between family theory and nursing practice (Duhamel, 1995; Friedman, Bowden & Jones; Segaric & Hall). A review of empirical family nursing literature suggests several barriers that make incorporation of family-focused care difficult to realize in clinical practice. These issues converge into three prevailing themes that serve as background to the research questions guiding this study.

The purpose of this chapter is to provide a synthesis of the challenges and gaps associated with application of family nursing theory to practice. The first theme addresses issues and problems related to language and conceptualizations of family (Gilliss, 1991; Hutchfield, 1999; Robinson, 1995b) \(^1\). The second theme attends to the inadequate explanation of contextual factors affecting family nursing, specifically in acute care hospital settings (Dunleavy, Shamian & Thomson, 2003; Galvin, Boyers, Schwartz, Jones, Mooney & Warwick, 2000; Levine & Zuckerman, 2000; Wright & Leahey, 2000) \(^1\). The third theme examines the lack of understanding about interactive

processes between nurses, patients, and family members in the planning and provision of nursing care (Bell, 1995; Hayes, 1997; Levine & Zuckerman; Ward-Griffin & McKeever, 2000).  

2.1 Issues Related to Language

Several issues are identified here that pertain to language. These include: lack of a common language, the theory-practice gap, family defined as context, family defined as unit, family defined as system, and the need for conceptual clarity. A more detailed discussion of each issue now follows.

2.1.1 Lack of a common language.

Well over a decade ago, Gilliss (1991) identified a critical need for a common nomenclature related to the units of assessment, intervention, and evaluation of family across nursing theory, research, and practice domains. In response, various theories and conceptualizations of family began to emerge; however, implementation of family theory to practice ‘lagged’ behind (Duhamel, 1995, p. 7). Many authors claim that the absence of family nursing practice in areas other than maternity care and pediatrics is due to the lack of a distinct and consistent vision of what constitutes family (Ganong, 1995; Hayes, 1997; Hutchfield, 1999; Robinson, 1995a; Vaughan-Cole, 1998). Moreover, Robinson argued that the variety of definitions of family currently in use do not serve to unify our perspective because a common language that crosses the domains of research, theory, and practice remains absent.

To complicate matters, no original family nursing theory exists (Friedman, Bowden & Jones, 2003; Vaughan-Cole, 1998). Consequently, the nature of family nursing is conceptualized using groups of concepts, principles, assumptions and hypotheses borrowed from other disciplines and compiled from existing general nursing theories and adapted to fit various philosophies of family nursing (Friedman, Bowden & Jones; Hanson & Kaaikinen, 2001; Wright & Leahey, 2005;
The multiple conceptualizations that result can leave nurses confused and frustrated in their efforts to discuss and to apply family nursing theory in practice. Indeed, the language of family nursing that has evolved lacks clarity and agreement about what family nursing actually encompasses (Denham, 2003; Segaric & Hall, 2005). As Segaric and Hall (2005) argued: “theoretical explanations [of family nursing] that are accessible are frequently characterized by obscure language and conceptual overlap, which makes achieving a common understanding within practice difficult” (p. 213).

2.1.2 Theory to practice gap.

Theoretical conceptualizations that lack clarity and fail to communicate the salient characteristics of the nature of family nursing and to guide nursing care are based on pre-existing constructs as opposed to experiential knowledge gained through doing (Bell, 1995; Friedman, Bowden & Jones, 2003; Hayes, 1997; Vaughan-Cole, 1998). This results in theory that lacks relevance and utility in practice, either because nurses are unable to determine meaning and relevance of the theoretical concepts, or the theoretical concepts fail to fit within the realities of practice – a situation referred to as the family nursing theory – practice gap (Hewison & Wildman, 1996; Segaric & Hall, 2005). The lack of relevance and utility of theory for practice is linked to: 1) the persistent influence of the bio-medical model which promotes ritualistic nursing practice (Anham & Johnston, 2000; Hanson, 2005); 2) the absence and dilution of family theory content in nursing curricula (Hanson, 2005); and 3) the failure of family theories and frameworks to account for the increasing complexity associated with both contemporary families and acute care practice settings (Hartrick Doane, 2005).

From the language has evolved three extremely complex yet persistent theoretical conceptualizations of family that are commonly used to guide family nursing education,
research, and practice. The three dominant conceptualizations are: family as context, family as unit, and family system theory. Although each conceptualization is generally regarded as distinct, theoretical elements of the concepts and sub-concepts are not only defined differently but also have similarity and overlap. Friedman, Bowden, and Jones (2003) acknowledged that multiple definitions of family can be found across the family nursing literature and there is little agreement about what family nursing actually encompasses (p.36). Friedman stated: “The way family nursing is practiced depends on how the family nurse conceptualizes the family and works with it.” (p.36). Her statement not only suggests lack of agreement as to what family nursing means, but also the extent to which it can be practiced.

2.1.3 Family as context.

The term family as context is most commonly linked with the family-centered care practice model in which family is conceptualized in one of two ways: individual as focus and family as context or family as focus and individual as context (Friedman, Bowden & Jones, 2003; Wright & Leahey, 2005). When the family is the focus the nurse concentrates on family members’ experience as caregivers coping with illness in another family member. Conversely, when the individual is the focus nursing care is directed primarily toward the individual patient; however, family involvement in that care is considered central to the individual’s overall well-being (Friedman, et al.; Newton, 2000). The way in which family is defined and exactly how family members are or could be ‘involved’ varies from one definition or description of family-centered care to another – if in fact it is described at all.

Anham (1994), for example, described family-centered care as a philosophy that calls for partnerships between parents and professionals that support parents in their central caring roles. Newton (2000) emphasized family as an essential part of the child’s care and illness experience
in her definition of family-centered care. Although each view implies a different view of family (parent(s) to a non-specific description of family), descriptive elements of family-centered care appear similar. These include notions of partnership, collaboration, participation, and communication. Notwithstanding, application of these elements in practice remains problematic and the meaning of each continues to be heavily debated (Gedaly-Duff & Heims, 2001). Issues involved in developing partnerships or collaboration include role stress, overlapping roles, negotiation failure (secondary to opposing care and treatment views), and power struggles between nurses and family members (Levine & Zuckerman, 2000; Newton; Ward-Griffin & McKeever, 2000).

While some authors (as in the examples above) consider the focus of care in family-centered care to be the development of collaborative partnerships with family for the purpose of promoting the well-being of the individual patient, others view family care as more holistic in nature. According to Anham and Johnson (2000), the holistic approach shifts the focus of care from the individual to all family members. Emphasis is placed on supporting family functioning as well as recognizing family diversity, vulnerability, risks, and strengths for the purpose of providing individualized care for all family members (Anham & Johnson; Hutchfield, 1999; Newton, 2000). Thus, each individual family member becomes the focus of care, although the scope and nature of the care provided remains unclear.

2.1.4 Family as unit.

Confusion about the scope of family nursing and the unit of care in family nursing is further compounded by views of family as client (Friedman, Bowden & Jones, 2003), family as unit (Wright & Leahey, 1990), and family group (Robinson, 1995a). According to Friedman et al. (2003), when family is considered client the entire family becomes the focus of assessment and
care. Friedman et al. stated: "The family is now in the foreground, while the individual family member is the background or context. The family is viewed as an interactional system" (p. 37). This description might be interpreted as an attempt to combine two somewhat contradictory theoretical conceptualizations of family (family as focus with individual as context versus focus on the whole family); each view is driven by opposing philosophical perspectives related to parts versus wholes. In practical terms, how does the entire family become the focus of care when individuals are relegated to the background? How can one be either a family member or an individual? Moreover, how might this view of family be implemented in acute care practice settings where the care priorities must first and foremost focus on the ill family member (patient)?

2.1.5 Family system.

Wright and Leahey (2005) have viewed the family as a unit or whole, requiring that the focus of nursing care be directed towards both the individual and the family simultaneously. According to Wright and Leahey (2005) when families are viewed as systems “it allows us to view the family as a unit and thus focus on observing the interaction among family members rather than studying family members individually” (p. 32). These authors remind the reader that each individual family member is both a subsystem of the family system and a system in their own right. This conceptualization of family falls under the category of systems nursing, whereby the whole (the family unit) is greater than the sum of its parts (Wright & Leahey). Wright and Leahey further posited that families are best conceptualized as a hierarchy of systems composed of a set or complex of interacting elements. A change in one system causes a change in other systems (Vaughan-Cole, 1998; Wright & Leahey). Since emphasis is placed on the interaction
between and among family members, family nursing from this perspective should include all family members.

Although the family systems approach has been identified as one of the most influential of family theory frameworks (Hanson & Kaakin, 1998), the idea of including all family members in care raises several semantic and organizational questions, especially in acute care practice settings. Definitions of family associated with systems theory, for example, tend to be comprehensive in nature, meaning that families are self-defined (Bell, 1995b; Friedman, et al., 2003; Leahey, Harper-Jaques, Stout & Levac, 1995; Wright & Leahey, 2005). While inviting the individual to define who constitutes the family may provide important access to beliefs about family membership and roles (Bell, 1995b), some important questions include: Whose view of family takes priority? What personal beliefs, practices and/or administrative factors promote or restrict nurses' abilities or willingness to honor families' unique definitions and configurations? If families are considered a hierarchy of interacting systems, then who is responsible for deciding the order of the hierarchy and on what basis?

Robinson (1995a) argued that conceptualization of family as parts versus wholes results in confusion related to the focus of care because "persons are conceptualized only at the level of family members, are encompassed by family, and are lower on the hierarchical order" (p. 23). This view of family sets up an artificial separation between individuals and families that Robinson (1995b) referred to as a dichotomy of either/or positions characterized by competition and exclusion. It is essentially reductionistic. Consequently, Robinson (1995a) preferred the term group to describe family because it is inclusive of both family and persons (individual and family member).
The family group is defined as “family is foreground and the individual/family members and their relationships are background” (Robinson, 1995a, p. 28). In other words, focus is concentrated on the overall attributes of the family group, while influence of individuals or relationships is obscured. While conceptualizing the family as group resolves the dichotomy between individual systems and family systems, the framework proposed by Robinson (1995a, b), which consists of different views or levels of nursing inclusive of both family and individual systems is, by her own admission, extremely complex and confusing. Moreover, some questions that need to be addressed include 1. What nursing practice implications are associated with shifts from individual systems to sub-systems to family systems? 2. How does a nurse make such shifts in family focus?

**2.1.6 The need for conceptual clarity.**

The persistent lack of conceptual clarity and consensus in terms of what constitutes family and family nursing has implications for future family nursing research aimed at bridging theoretical conceptualizations and the realities of clinical practice. As emphasized by Chinn and Kramer (1999), clarity in conceptual meaning is fundamental to the process of theory development and testing. One of the implications of conceptual clarity is that a similar empirical reality for the concept comes to mind as nurses read the theory (Chinn & Kramer). Hardy (1978) argued that it is important that a theory's significant concepts and conditions be applicable to practice realities and be modifiable depending on the clinical situation.

To date, the absence of research linking the various conceptualizations of family with clinical practice is startling (Friedman et al., 2003). Indeed, Hayes (1997) argued that nursing has failed to capture the interconnected nature of family theory and practice. In other words, although family nursing is known to exist in daily practice, Hayes maintained that nurse scholars,
educators, researchers, theorists, and practitioners alike have just scratched the surface in their effort to define what family nursing is and determine how to conceptualize its processes let alone explain how to do it.

Bell (1995) argued that a search for a common language to describe family nursing must be taken to the practice domain to achieve conceptual description that accounts for the bi-directional influence of what constitutes a family intervention in practice (Bell, 1995). Most recently, Hartrick Doane and Varcoe (2005a; 2005 b) argued that family nursing theory, which was founded on primarily objective forms of knowledge, constrains nurses' ability to respond to the unique health and healing processes of families and limits choices in clinical decision-making. Moreover, Hartick Doane and Varcoe (2005a) maintained that when nursing practice is informed by “multiple knowledges [sic],” including experiential, contextual, spiritual, theoretical, biomedical, ethical, and ideological knowledge, nurses are able to be much more responsive to the unique needs of individuals and families (Hartrick Doane & Varcoe, 2005a). Consequently, Hartrick Doane and Varcoe (2005a; 2005b) advocated for a relational approach to family nursing knowledge development and practice.

According to Hartrick Doan and Varcoe (2005a) the relational lens provides a view of the world that is concerned with the interconnections between people, situations, contexts, environments, and processes. In her description of a relational stance, Tapp (2000) emphasized the need for nurses to maintain a respectful regard for families’ perspectives in care. O’Sullivan Burchard (2005) proposed that regarding family nursing as a relational practice could advance a shared perspective or what she referred to as an ‘ethos of family nursing’. An ethos of family nursing is represented by complimentary interpersonal relations between nurses and families in which nurses respectfully learn about how families make sense of illness and purposefully
acknowledge the individuality of families in care (O'Sullivan Burchard; Tapp). Common to these perspectives is the belief that, whether or not a relational approach has the potential to provide a new paradigm of care for families (O'Sullivan Burchard), it can advance family nursing practice because it grounds knowledge development in 'real' experiences and practices that take place in the contingent and ever-changing world of family nursing (Hartrick Doane & Varcoe; O'Sullivan Burchard).

Because the value placed on knowledge largely depends on its utility in practice, initiatives in family theory development by practitioners or theories that account for these various perspectives in practice are gaining support (Bell, 1995; Hartrick Doane & Varcoe, 2005a; Hutchfield, 1999). As discussed previously, one of the main objectives of this study is to generate theory to describe how nurses, patients, and family member(s) manage relationships around planning and providing care in acute care hospital settings – and to do so from the perspective of nurses, patients, and families. This work is timely in that it has the potential to make a valuable contribution the development of a conceptualization of family nursing that is meaningful to nurses, patients, and families and aids in efforts to bridge the gap between family nursing theory and acute care hospital practice.

2.2 Issues Related to Contextual Features

Several issues related to contextual features in the practice environment that constrain or prevent the application of family nursing theory to practice are now described. Such issues include: failure to account for the work environment, lack of nursing time, and the implications of time for nurse-family relationships.
2.2.1 Failure to account for the work environment.

A second theme associated with the problem of the family theory-practice gap is the claim that family theory may not adequately account for contextual factors that can constrain nurses' efforts to include families in care. This may be because, to date, relatively limited attention has been paid to nurses' work environments (McGillis-Hall & Kiesners, 2005). Indeed, only in recent years has the true impact of the hospital restructuring of the 1990s been realized. Publications have warned about the serious and rapid deterioration of the quality of work life for nurses and its effects on nurses, the system, patients, and families (McGillis-Hall & Kiesners).

In an effort to better understand the impact of the working environment on the health of the nursing workforce in Canada and to make recommendations for improvements, Baumann, O'Brien-Pallas, Armstrong-Stassen, and colleagues (2001) conducted an analysis of published and unpublished literature concerning the health and well-being of Canadian nurses in the workplace and focus group data from nurses and other stakeholders. Based on their findings, they cautioned that, while nurses' work has always been demanding, nurses are facing serious challenges in increasingly difficult work environments. Heavy workloads, long hours, low professional status, difficult relations in the workplace, difficultly carrying out professional roles, and a variety of workplace hazards create stressful working conditions for nurses (Baumann, O'Brien-Pallas, Armstrong-Stassen, et al.), which lead to burnout, decreased nursing recruitment and retention, and negative outcomes for patients, systems, and families (Baumann, O’Brien-Pallas, Armstrong-Stassen, et al.; McGillis-Hall & Kiesners, 2005). Similar findings have been reported in follow-up studies by Greenglass and Burke (2002) who found that nursing burnout, particularly emotional exhaustion, and cynicism was linked to stressors associated with hospital
restructuring initiatives, workload, and deteriorating hospital facilities and services (for example, cleanliness, building repairs and general appearance).

With the aim of assisting hospitals to address work life issues for nurses and to create quality work environments, McGillis-Hall and Keisners (2005) interviewed Canadian nurses working on medical and surgical units across Canada to determine what work environment issues were important to them. Three main sources of work-related stress were identified: high levels of patient acuity; high levels of workload and understaffing; and lack of adequate patient care. The authors linked increased patient acuity (sicker patients with complex, multi-system conditions) to an aging population and a reduction in moderately ill patients who are being treated on an outpatient basis. Increased acuity was found to increase responsibility, time pressures, and stress in nurses’ everyday work. McGillis-Hall and Keisners indicated that escalating workload compounded by staff shortages resulted in nurses reporting a decrease in the provision of quality care and concern for their own and their patients’ safety. Although this study clearly suggested that deteriorating nursing work environments affected nurses’ abilities to provide quality care, how these working conditions affected nurses’, patients’, and family members’ relationships in acute care hospital settings remained unclear.

Several authors have maintained that nursing shortages, decreased length of patient stay and increased patient acuity have resulted in less nursing time spent with patients and families (Galvin, Boyers, Schwartz, Jones, Mooney & Warwick, 2000; Levine & Zuckerman, 2000, Wright & Leahey, 1999; 2000). Authors claim that sicker patients require closer supervision and complex nursing interventions leave little or no time to meet emotional or other needs of patients or families (Dunleavy, Shamian, Thomson, 2003; Friedman, Bowden & Jones, 2003). Rutledge,
Donaldson and Pravikoff (2000) argued that family needs are often inadvertently neglected by staff focused on moment-to-moment demands of patient care.

2.2.2 Lack of nursing time.

Dunleavy et al. (2003) examined the effects of hospital organization and staffing on patient outcomes and identified the problem of insufficient nursing time. The over eight thousand (8,000) nurses they surveyed reported that it was a struggle to keep up with increasing numbers of non-nursing roles and responsibilities (for example, paperwork, housekeeping, switchboard operator); they felt burnt out and dissatisfied with their work. They regretted their lack of time to provide balance between medical and psychosocial care for patients and their families (Dunleavy et al., p. 25).

Although lack of nursing time is often cited in the literature as a primary barrier to applying family theory in acute care hospital settings, and we would expect that inadequate time for patients' needs would translate into lack of time for family needs, there is limited evidence to support this conclusion. Indeed, the publications reviewed by this author revealed a dearth of empirical research which specifically investigated how time promoted or inhibited family nursing practice in acute care settings. In a pilot study examining family members' experiences of their role in a hospital (n=70), Astedt-Kurki, Paunonen and Lehti (1997) found that only one-third of the family members sampled felt that nursing staff were seriously interested in the family's well-being. Participant responses were partly based on the lack of spontaneous information they felt they received from nurses, as well as the effort required on their part to seek out nurses for information and support. Although the authors suggested that decreased nursing time might be a factor in the lack of communication and information shared between nurses and
families, the researchers did not account for contextual explanations from either families’ or nurses’ perspectives.

Keatinge, et al. (2002) noted that consumer involvement (broadly defined as consumers of nursing care services) in health care is desirable but generally not implemented due to poor consensus about what participation means and nursing apprehension about partnering with families due to lack of time and their extra space requirements. In an effort to determine what barriers exist in nurse-consumer partnerships and why, Keatinge et al. conducted an 8 month pilot study using an audio-taped workshop format. Findings indicated that communication was the principal barrier identified by both acute care nurses (N = 199 Registered Nurses) and consumers (N = 36). The contexts in which communication barriers occurred were grouped by theme. They included: information transfer, documentation, education, personal and interpersonal situations, guidelines and policy, organizational structures, politics, and, lastly, resources and time. Each theme was labeled on the basis of recurring terms used by participants to describe a communication-related strategy or situation. Despite the fact that several systemic themes, including resources and time, were identified, the study was limited by the lack of consideration of possible relationships between themes. Moreover, the second phase of the study – which was to generate strategies to improve communication, focused on only the information transfer, documentation, and education themes, as these were the top three priorities identified by participants. Consequently, recommendations arising from the study were limited to improving communication processes in isolation of the effects of context on communication processes.

Using a descriptive survey design, Galvin et al. (2000) sampled 193 participants (either maternity patients or parents of a hospitalized child) in a large tertiary care hospital to explore participants’ perceptions related to the family-centered care philosophy being piloted. One of the
hypotheses of the study was that, despite widespread support of family-centered care, family-centered philosophy remains inconsistently operationalized in hospitals due to numerous barriers to implementation including space and time constraints and the ability to meet the physical needs of the patient. Results suggested that, faced with limited time, nurses’ priorities may be the patient’s physiologic needs and the technological demands of the environment. They did not seem to perceive their time and resources to be adequate to provide support to patients and their families (Galvin et al.). Although the authors found that items measuring staff inclusion of family in care were rated higher on level of importance and lower on level of occurrence, they did not explain this discrepancy or its effects on nurse-family relationships.

2.2.3 Implications of time for nurse-family relationships.

Limitation in nursing time has also been associated with the type of nurse-family relationship that is established in the clinical setting (Levine & Zuckerman, 2000). Although most family nursing theoretical frameworks call for the development of collaborative partnerships between nurses and family, time constraints may force nurses to assume a less collaborative and more functional approach with families. Hutchfield (1999) referred to this as the role of gatekeeper and dominant player in the partnership where nurses decide in which care families can participate and delegate accordingly.

Nurses’ abilities or willingness to invest time in the establishment of collaborative partnerships with families has also been linked to nurses’ beliefs about their roles and responsibilities to patients versus families. As Levine and Zuckerman (2000) pointed out: “there are deeply rooted reasons for conventional attitudes that overlook or denigrate the role of family members in patient care and decision-making” (p. 6). Medical practice and bioethics, which have both heavily influenced the development of nursing practice, have viewed individual patients as
the primary if not sole focus of concern and care. This traditional view of patient continues to
direct medical and nursing allocation of time in many settings, thereby placing family in what
Yates (1998) referred to as an ambiguous position in health care. The individual focus
dominating health care limits opportunities for professionals and families to understand each
other’s issues and concerns (Yates).

Wright and Leahey (2005) supported the notion that social and contextual factors play an
important role in the distribution of nursing time. According to these authors, social coordination
is a function of time that gives it instrumental value in health care. In nursing, time is “socially
and culturally coordinated, highly ritualized and therefore honored” (Wright & Leahey, p. 264).
The degree to which families are also honored may well determine the likelihood that nurses will
alter their practice contexts to increase their caring for and inclusion of families in practice
(Wright & Leahey).

Despite evidence that families can have significant influence on promoting the well-being of
their ill family members, families continue to be widely excluded or marginalized by health care
professionals generally and by nurses specifically (Astedt-Kurki, Paunonen & Lehti, 1997;
Wright & Leahey, 2005). Such an observation begs the question: What does it mean to honor
families in health care so that they are seen to be worthy of nursing practice time? Wright and
Leahey maintained that nurses must alter their constraining beliefs about involving families;
however, it is acknowledged that altering practice is complex because it involves a combination
of administrative support, family-friendly facilities and nurses who are committed,
knowledgeable, and skilled at involving families in care (Wright & Leahey).

Wright and Leahey (2005) also emphasized that any involvement of family members is
superior to no involvement. The authors introduced the 15-minute assessment framework
consisting of five essential ingredients: manners, therapeutic conversations, family genogram and ecomap, therapeutic questions, and commendations to account for limited nursing time. The framework was designed to provide an efficient means of incorporating family interviews into nursing care. Wright and Leahey argued that, for nurses to make time in their hectic schedules, even for a brief interaction, they should modify their beliefs to embrace the philosophy that illness is a family affair (Wright & Leahey). But is it simply a matter of changing nursing beliefs or are other larger forces at work creating barriers to nurses' best intentions to involve families? What are the structural factors that reinforce socially and culturally coordinated nursing time in ways that exclude families? How much is actually understood about the nature of constraints such as lack of time and other barriers that are only surfacing as a result of the challenges in contemporary practice settings?

2.2.4 Other contextual issues affecting nurse-family interaction.

In addition to time constraints, legal, administrative, and building design issues add complexity to providing family care and require further investigation in terms of their effects on nurse–patient and family relationships. Levine and Zuckerman (2000) argued that the structure and practices of the health care system force health care professionals into adversarial positions with families. According to these authors, while some clinicians are sensitive to the needs of families, many have their efforts to engage and support families thwarted by organizational requirements and poor reimbursement. For others, the dominance of medical and bioethical models that privilege professional knowledge and some patient needs create situations in which families are considered as suspect and distracting entities that disrupt institutional routines and authority (Levine & Zuckerman). These authors claim practitioners may also fear litigation from angry or disgruntled family members which may prompt them to focus more on individual
patient needs and limit or prevent family members from observing or participating in direct care in case something goes wrong.

Institutional policies that limit the number of people that can visit safely and/or any other policies that restrict family members’ access to their ill family members are also practice realities commonly believed to decrease family nursing initiatives. In a study conducted by Galvin et al. (2000) on maternal/child units, parents surveyed rated respect, collaboration, and support as critical elements of a family-centered care philosophy. Respect included having access to their child, making them feel more welcome in the hospital environment, assisting them in maintaining their parental role, and acknowledging parents’ rights to question medical recommendations. As a result of this study, visitation policies in the participating hospital were expanded to include grandparents and siblings, the frequency that parents were required by policy to leave the bedside (e.g. during nursing report) was decreased, and greater overall emphasis was placed on enhancing and supporting nurses’ efforts to value parent participation in care. The outcomes of these changes were not reported.

Barriers to family access associated with building design are cited in several studies; however, the importance of these issues varies. In their synthesis of the literature, Rutledge, Donaldson, and Pravikoff (2000) found that implementation of family-centered care is often inhibited by structural or architectural barriers, such as waiting rooms that isolate family members and/or prevent them from staying at the bedside. Similarly, Lee and Craft-Rosenberg (2002) noted that formal and informal structures associated with hospitals, as well as inconsistencies in visiting policies, posed real barriers to the provision of services and participation by families in care. Verhaeghe, Defloor, Van Zuuren, Duijnstee, and Grypdonck’s (2005) review that pertained to the needs and experiences of family members of intensive care
patients indicated that the 'practical needs' of families in the hospital environment are generally considered less important by hospital staff and family members. These authors cautioned that the notion of physical needs can be interpreted to include everything from visiting hours to the availability of material items and conveniences such as comfortable furniture, blankets, a place to lie down, and close proximity to a bathroom. Generally, family members placed higher importance on the need for flexible visitation rights than did hospital staff. Material needs tended to be ranked lower in priority by both hospital administrators and family members. In their analysis of the perceived needs of Jordanian families of hospitalized, critically ill patients, Al-Hassan and Hweidi (2004) found that families' needs for information ranked highest in priority, whereas items associated with comfort including visiting times, waiting rooms, and other comfort measures were ranked lower.

Incorporating family nursing care in acute care settings is complex and involves interacting and possibly opposing contextual and systemic forces. While nurses are being called upon to involve families in care, time constraints require that they develop ways to do so in an expedient and effective way (Friedman, Bowden & Jones, 2003; Wright & Leahey, 2005). It is clear that the degree of family-centeredness that is attainable may be dependent, at least to some extent, on any one of a number of factors including the set of beliefs and values held by the nurse (Wright & Leahey), the philosophy or support provided by the system within which the nurse works (Friedman et al.), and physical barriers that prevent or discourage family involvement in care in acute care hospital settings (Rutledge et al. 2000).

Despite many studies that address contextual and systemic factors associated with nurses' abilities to incorporate families into their practice, there seems to be limited agreement and understanding about the significance of these factors and the extent to which they promote or
inhibit nursing efforts to involve families in patients’ care. Of particular note is the lack of research that takes into account the perspectives of nurses, families, and patients. For family nursing to advance in acute care settings, we must gain a better understanding of the contextual and systemic factors or structural conditions that affect nurse, patient, and family relationships.

2.3 Issues Related to Interactive Processes

A third theme associated with the family theory – practice gap concerns the paradox of the importance placed on nurses’ work with families and the lack of understanding about the nature and development of nurse-family relationships in acute care settings. While theoretical knowledge and conceptualizations of family have grown and evolved at an exponential rate, understanding of processes that occur between nurses and families in care has been slow to develop (Bell, 1995; Vaughan-Cole, 1998; Griffin-Ward & McKeever, 2000). The advancement of theory rather than practice has been linked to gaps and limitations in knowledge about how nurse-family interactions are conceptualized or actualized in practice. Some scholars, for example, have suggested that family nursing theory based solely on objective knowledge fails to promote nurses’ development of interactions with families beyond a superficial level, prompting them to advocate for a more relational conceptualization of family (Hartrick Doane & Varcoe, 2005; O’Sullivan Burchard, 2005; Wright & Bell, 2004). Hartrick Doane and Varcoe have maintained a relational stance is necessary, because family theories are decontextualized and depersonalized and, therefore, lack meaning and utility in practice.

Several other problems hamper the conceptualization and development of nurse-family interactions in clinical practice. For example, the literature privileges research for theory development over research examining the interface between family theory and practice (Hayes, 1997; Vaughan-Cole, 1998). Hayes identified problems with the lack of resources available to
assist practicing nurses to understand the possibilities, expectations, and scope of their interactions relative to families. Furthermore, Friedman et al. cited lack of evidence to support the efficacy of family nursing strategies and programs. In the context of cancer patients and their families, Yates (1999) argued that conceptualizing the relational and reciprocal nature of family members' needs and determining ways of dealing with conflicting needs in practice are challenging. Allen (2000) argued that how family caregivers interact with the 'service system' in the acute care hospital context is poorly understood. Finally, Wright and Bell (2004) maintained that only by altering their way of thinking about who is patient will hospital nurses gain greater insight into families’ experiences of illness and discover intervention alternatives.

Many studies have presented ideal goals for nurse-family relationships, but have based their claims on the perspectives of either nurses or families, but not both groups of participants. Few studies have sought to understand multiple perspectives, and, no studies have examined family nursing interactions or interventions from nurses’, patients’ and families’ perspectives. For example, a frequently cited grounded theory study by Robinson and Wright (1995) identified giving of information, maintaining a non-judgmental, compassionate, and genuinely interested stance, and the use of therapeutic conversations as nursing interventions considered most helpful by families. The study was limited by its location in the family nursing unit—a research and educational unit associated with the University of Calgary, its focus on families coping with chronic illness, its inclusion of only Caucasian families, and its lack of input from nurses about practice realities that can impede or prevent implementation of such strategies. The recommendations for nursing from the study were also limited because nurses' views were not included in the sample.
Astedt-Kurki, Lehti, Paunonen, and Paavilainen (1999) explored experiences of family members when their next of kin were admitted to hospital. The authors identified three main classifications of family experience: fear and worry; disruptions and changes in everyday life; and extended periods of time spent helping the patient. They recommended that nursing strategies, aimed at supporting and assisting families in providing care, ought to take into account the uniqueness of families' experiences of the hospitalization of a relative. Although the study provided insight into the experiences of families in their roles as caregivers, it is limited by the fact that 80% of the respondents were female spouses of the patients and patients were receiving treatment at an acute neurological ward of a large hospital. Because data were collected via questionnaires mailed to a family member who patients identified, neither patients' nor nurses' views were investigated.

A consistent lack of nursing input for studies about relationships with nurses could contribute to nurses' feelings of guilt, anger, and confusion associated with the disparity between how nurses ought to 'be with families' and factors that prevent them from doing so – even if they believe it is important. Nurses may also feel betrayed due to the lack of investigation into how they promote family involvement. Practicing nurses may view studies that do not include their perspectives as irrelevant, because they fail to resonate with the realities of practice experienced by those working in the clinical setting.

Nurse-family relationships are also poorly understood in terms of contextual factors, including culture and long held beliefs associated with families and family roles in health care. Lee, Chien, and Mackenzie (2000) noted the effect of critical illness on family members and the importance of nursing care inclusive of family is well documented in American studies. Unfortunately, these studies are primarily based on the Western culture and fail to account for
differences across various ethnic or racial groups. Indeed, Lee et al. expressed surprise at the lack of research related to the Chinese population given their cultural beliefs about the significance of family and the importance of maintaining family relationships, roles, and obligations in order to preserve equilibrium within the family system. Levine and Zuckerman (2000) noted the potential for increased conflict between families and health care providers when families operate from different religious, cultural, or ethnic backgrounds than those of care providers.

Beliefs and expectations that nurses' hold about families and, conversely, beliefs and expectations that families hold about health care providers require further investigation to determine their effects on promoting or inhibiting nurse-family relationships. Kellett (2000) emphasized the competitive relationships that often occur between families and professional caregivers in the context of long term residential care facilities, because families are traditionally expected to relinquish care to the bureaucracy and failure to do so may be looked upon as interference. Families often work to improve the quality of care experience for their kin; however, some studies have indicated that professional caregivers may view this as interfering with routines (Kellett; Levine & Zuckerman, 2000) or implicit criticism that nurses are not doing a good job (Kellett). Levine and Zuckerman have argued that often family involvement is seen as a challenge to the power and authority of professionals and institutions.

Health professionals often consider families to be dysfunctional and incapable of participating in decision-making (Levine & Zuckerman, 2000). Such judgments block the development of collaborative nurse-family relationships. Family behaviors, especially during times of stress or crisis, are often misinterpreted or poorly understood by healthcare providers (Kellet, 2000). Levine and Zuckerman suggested that many health professionals believe that families are generally disintegrating and dysfunctional. Such beliefs have been perpetuated by a few
legendary, truly dysfunctional family cases, by families that are known in terms of legal precedent, or by heroic families by which all other families are measured. Family nursing research that aims to explicate underlying beliefs and assumptions held by families, patients, and nurses in the context of acute illness episodes will increase our understanding of the nature of their relationships under common conditions.

Notwithstanding the various constraints and challenges in explicating nurse-family interactions in clinical practice, a number of factors - as perceived by nurses, patients, and family members - that facilitate positive nurse-family relationships appear repeatedly in the family nursing literature. In a complex, multi-phased grounded theory study to examine the development of nurse-family relationships in the intensive care unit (ICU), Hupcey (1998) identified numerous facilitative and constraining strategies used by nurses and family members. Due to the extensive nature of the study and the number of outcomes reported, the findings are presented here in an abbreviated format.

Hupcey (1998) indicated that strategies identified by nurses as facilitative in demonstrating their commitment to families included: spending time, providing explanations, encouraging participation, and anticipating family members’ needs. Those facilitative in building relationships with families were spending time, getting to know family members, and sharing personal information. Nurses used strategies to demonstrate ongoing involvement with families, such as spending increased time, becoming a family advocate, and stretching or breaking the rules. Strategies used by family members to develop relationships with nurses included assessing for evidence of nursing competence, kindness, and genuine interest toward the ill family member; making an effort to be ‘good visitors’; and displaying trust by accepting nurses’ explanations, seeking nurses’ advice, relinquishing vigilance with the patient. Being over-or
under-involved in patient care and displaying a lack of trust in the nurse were family behaviors reported by nurses that they perceived inhibited the development of nurse-family relationships (Hupcey).

In Hupcey’s (1998) study, nursing behaviors perceived by family members to inhibit nurse-family relationships included depersonalizing the patient by not calling the patient by name and not making eye contact; not encouraging family participation in care; maintaining an efficient attitude by acting too busy to answer questions; displaying a lack of trust in the family by not listening to their concerns, and asking them to leave the room. Upon verifying the occurrence and negative impact of their behaviors, nurse participants cited being preoccupied, extra busy, and feeling the need to retain power and control as contributing factors. Although limited to ICU situations and not inclusive of patients’ views, a major conclusion of the study was that most families believed that facilitating relationships with nurses was of benefit the patient. Conversely, they viewed alienating the nurse as negatively affecting many aspects of patients’ care including obtaining information and participating in decision-making related to the patient—a reminder that nurses must be mindful of their actions and their effects on families (Hupcey).

Another limitation of this study was that it did not examine strategies that facilitated or constrained the development of nurse-family relationships from nurses and family members’ perceptions about self and others, and structural features.

Although limited to the perspective of nurses, Astedt-Kurki, Paavilainen, Tammentie, and Paunonen-Ilmonen (2001) found that the most important factors that facilitated nurse-family interactions in acute care hospital settings from the perspective of staff nurses included discussion opportunities provided by staff and the patient’s positive attitude toward staff-family interactions. Additional factors that contributed to the development of nurse-family interactions
included the family’s level of interest in the patient and the confidence that family members showed toward the nurse. Factors that were considered by nursing staff to complicate nurse-family interactions included: nurses’ haste; shyness by either the nurse or especially the family in terms of approaching each other; inaccessibility of staff and shift work; and patient’s resistance to nurse-family interactions. Also, despite nurse participants’ perceptions of their interactions with family as being fairly important, interactive episodes were considered rare, were seldom nurse-initiated, and almost always were limited to aspects of the patient’s condition and care.

Contrary to Hupcey’s (1998) results, although nurses’ haste was also seen as a primary complicating factor in nurse-family interactions, it was the nurses’ attitudes toward family members and their recognition of the family’s importance to the well-being of the patient that was seen to underlie hasty behavior by nursing staff as opposed to lack of time (Astedt-Kurki et al.).

Nurses’ attitudes towards patients’ family members and the importance of family in the well-being of the patient, as well as the value of providing information to family members, have clearly emerged as dominant themes in the literature associated with interactive processes between nurses, patients, and families (Astedt-Kurki et al., 2001; Auerbach et al., 2005; Majassaari, Sarajarvi, Koskinen, Autere & Paavilainen, 2005; Wright & Bell, 2004). In a study measuring family members’ satisfaction with needs being met during intensive care hospitalization, Auerbach et al. found that, although family members experienced high levels of anxiety and fear associated with sudden hospitalizations of ill family members, their needs for information, clear explanations, and knowledge about equipment being used, especially upon admission, were least satisfied. Nursing initiatives to improve communication (for example, family conferences) foster a sense of optimism and control in family members by maintaining a
positive attitude and encourage participation in care. Those elements were linked with a reduction in family member anxiety (Auerbach et al.).

In Majassaari et al.'s (2005) survey of day surgery patients about the importance of information and emotional support provided to their family members, the need for emotional support to ease family members' nervousness, fear, and anxiety associated with the surgical process was noted. Patients also identified strengthening of patient-family relationships around surgical episodes and enhancing family coping and well-being through family members’ presence and mutual support. Because patients perceived that nurses were too busy, did not meet with family members, and provided inadequate explanations or no information at all to families, recommendations from the study call upon nurses to be “more sensitive, perceptive, and present” to the unique needs of patients and families (Majassaari et al.).

Despite the dearth of family nursing research aimed at identifying strategies for nurse-family interaction and limitations in studies that have been undertaken, a common theme underscores the importance of ways of developing relationships with families and incorporating them into nursing care. The assumption is that illness in one family member not only affects all other family members, but also affects them in ways that are unique to the patient and the family (Tapp, 2000b; Wright & Bell 2004; Wright & Leahey, 2005).

Seeking to establish nurse-family relationships for the purpose of understanding and meeting the unique needs of families may be the primary goal of family nursing, but it is far more complex than meeting needs. As discussed in this section, numerous facilitative and constraining strategies, behaviors, and situations have been identified and others are yet to be explicated. Examining how personal factors (beliefs, values, experiences) affect nurses', patients’ and family members’ perceptions of their interactions to plan and provide patient care would contribute to
the identification of nursing interventions with families that are both helpful and realistic within the constraints of the acute care hospital settings.

2.4 Summary

The centrality of families to health care continues to gain support; however, there are challenges to efforts to incorporate family theory into acute care practice. Based on a review of extant family literature, it is evident that there are issues, constraints, and barriers that make family nursing difficult to realize in clinical practice. These difficulties converge under what has been described in this chapter as three prevailing themes: issues related to language, contextual features, and nurse-family interactive processes. They serve as the basis of the theory-practice gap observed in family nursing.

I have indicated that there is progress being made toward identifying strategies that facilitate the development of nurse-family relationships in practice. Examples of facilitative themes included: providing information, being supportive, maintaining a positive attitude, and spending time. Limitations in the knowledge obtained to date and how it has been generated have prompted a call for an examination of practice in order to understand how nurses, families, and patients conceptualize each other and navigate or remove barriers to engage with each other in care. In the next chapter, I present the theoretical perspective of symbolic interactionism selected to guide this study.
CHAPTER THREE

3 Theoretical Framework: Symbolic Interactionism

The purpose of this chapter is to describe the theoretical framework of this interpretive research study. Interpretivist research is concerned with the meaning of human social action. Finding meaning in the action of others requires interpretation (Schwandt, 2000) or what Charon (1979) referred to as ‘perspective’. A theoretical framework reflects a researcher’s theoretical perspective or a particular set of epistemological, ontological and methodological assumptions and beliefs about the world and how it is understood and studied (Denzin & Lincoln, 2000) and provides justification, context and logical grounding for the particular research design implemented (Crotty, 1998). In other words, one’s theoretical perspective allows one to make sense of and describe the reality to which one is exposed.

There are a number of theoretical perspectives within the interpretivist paradigm that espouse philosophical views about the nature of reality (ontology) and of knowledge (epistemology). Each perspective makes particular demands of the researcher in terms of the mode and meaning of the process of inquiry undertaken and the interpretation of findings (methodology). In conducting interpretive research, I must consider not only how I am situated philosophically but must also examine the fit between my beliefs and the theoretical perspective that informs the strategy of inquiry I use. I must also be concerned with justifying and defending the process of inquiry in which I have engaged by making it explicit to the scrutiny of others (Crotty, 1998) and by making explicit the philosophical stance that provides the context for the research process and grounds its logic.

Since my research study is concerned with gaining understanding about issues of language, communication, interaction and social context in relation to the management of relationships
among patients, nurses, and family members, I have chosen symbolic interactionism to ground my study. Symbolic interactionism focuses on the meaning of basic social interactions from the perceptions, attitudes and values of the actors (Crotty, 1998). To set the stage for my methodology and to make explicit the assumptions upon which this study rests, the purpose of this chapter is to provide a more detailed description of the philosophical and theoretical underpinnings of symbolic interactionism.

3.1 An Overview of Symbolic Interactionism

Symbolic interactionism is commonly described as a unique and relatively distinct American sociological and social psychological perspective on life, society, and the world (Blumer, 1969; Crotty, 1998; Denzin, 1992). Although the thoughts of many prominent scholars (e.g. Cooley, James, Dewey, Darwin) over several decades contributed to the intellectual foundation upon which symbolic interactionism rests, the perspective is based primarily on the work of social psychologist and philosopher George Herbert Mead and sociologist Herbert Blumer. While Mead is frequently referred to as the champion of symbolic interactionism, it is Blumer, a long time student of Mead’s, who is credited with interpreting and developing Mead’s ideas into a more systematic sociological approach. Indeed, it was Blumer who coined the term Symbolic Interactionism in 1937. According to Blumer the label symbolic interactionism refers to “the type of interaction that makes significant use of gestures or symbols” (Blumer & Morrione, (Ed.), 2004, p. 22).

Symbolic interaction rests on a process of social interaction based on interpretation of symbols. Inherent to this view of social interaction are, as expressed by Blumer (1969), three basic assumptions or premises. The first premise is that human beings act toward things (gestures or symbols) based on meaning. Secondly, meaning of symbols is derived from or arises out of
social interaction. Third, meanings are perceived and modified through an interpretive process. In other words, human beings act on things within their social world based on the meaning things have for them. Meaning is derived from interaction with self and others and in turn influences further interaction (Denzin, 1992).

3.2 Pragmatism

In the formulation of the main premises underpinning the social interaction perspective noted above, both Mead and Blumer were strongly influenced by pragmatist philosophy. Pragmatism emerged from the philosophical beliefs of such scholars as Pierce, James, Dewey and Mead – all of whom were disillusioned with the prevailing determinist philosophy (e.g. positivism) because it resulted in views about human behavior that lacked relevance to ‘everyday’ situations people experience (Atkinson & Housley, 2003; Charon, 1979, Prus, 1996). Pragmatist philosophies emphasize the importance of exploration and interpretation of human engagement in the social and natural world (natural sciences), (Atkinson & Housley). Pragmatists believe that human beings are not “passively shaped” (Charon, p. 30). Mead (1938), for example, maintained that people are emergent beings because of their ability to reason and use symbols. In other words, individuals act as independent forces who are actively involved in planning and carrying out action in response to their environment. They cannot be explained by simply isolating forces that act upon them (Charon). Human action is characterized by continuous adjustment or adaptation in order to master the conditions of their environment (Reynolds & Herman-Kinney, 2003) and to find solutions to practical problems (Prus, 2003).

Further to the central pragmatist principle of human beings (organisms) in interaction with their environment is the notion of selective perception. Selective perception is the process by which individuals attend to only certain aspects of a situation (Reynolds & Herman-Kinney,
Human beings are constantly bombarded with stimuli; they must select those stimuli or aspects of the environment that are relevant and/or have utilitarian value to the act in which they are engaged. Through this selection process, individuals actively engage with their environments and are therefore considered self-determining vis-à-vis their environments (Atkinson & Housley, 2003; Crotty, 1998; Reynolds & Herman-Kinney).

Pragmatism, as it relates to interpretivism, also focuses on communication stimuli and their consequences (Maines, 1997). Communication is grounded in the human ability to use symbols that are associated with various cultural and social utilitarian meanings that affect social interactions. Blumer (1969) maintained that human beings act toward symbols or objects (everything that the human being may note in his world) based on the meaning they attribute to the objects. In other words, meaning is derived not from the object itself but instead is socially constructed on the basis of how people act in response to the object (Crooks, 2001). Since symbols may have multiple meanings, individuals engage in a process of selecting and communicating/acting on the meaning that is most practical to the situation. Actors are capable of reason, expressing preferences, and exercising choice (Lal, 1995). In the process of studying interactions among nurses, patients, and families it is important to consider key concepts such as human agency, communication, meaning, and social process. These concepts strongly resonate with symbolic interactionism (Prus, 2003).

Not surprisingly, the similarities between pragmatism and symbolic interactionism have led many to speculate that it is through the theoretical perspective of symbolic interactionism that pragmatist philosophy entered the world of sociology and social psychology (Crotty, 1998; Reynolds, 2003). Prus (2003) maintained that many of the pragmatist insights about human behavior have been “absorbed by and recast” into the symbolic interactionist perspective of
today (p. 48). This intimate relationship between pragmatism and symbolic interactionism becomes even more apparent when the ontological, epistemological and methodological underpinnings of symbolic interactionism are explored – the focus to which I now turn.

3.3 Ontology

Two pragmatist philosophical principles are reflected in the basic assumptions about reality held by symbolic interactionists. These ontological principles state that reality exists only as interpreted and defined by the individual, and secondly, that individuals define objects or symbols on the basis of perceived utility (Charon, 1979). Each principle will now be discussed in turn.

The first principle is that reality is only possible through an individual’s own intervention or in other words, reality does not exist without our interpreting and defining it (Charon, 1979). This is not to suggest that there is no objective reality outside human interpretation, indeed, symbolic interactionism maintains that a physical objective reality does exist. Physical objects in relation to human beings are considered social objects that represent meaning from the perspective of individuals as they interact with others. According to Blumer (1969):

The meaning of a thing for a person grows out of the ways in which other persons act toward the person with regard to the thing. Their actions operate to define the thing for the person. Thus, symbolic interactionism sees meanings as social products, as creations that are formed in and through the defining activities of people as they interact (p. 4-5).

Reality is expressed through a system of symbols that reflect social life.

Blumer suggested that social interaction through symbols assumes two forms, which Mead designated as ‘conversation of gestures’ and ‘use of the significant symbol’ (Blumer & Morrione (Ed.), 2004). A gesture is seen as an abbreviated or portion of a larger action - a stimulus that presupposes a response in the form of a forthcoming action. Because the meaning of gestures is
implicit in the gesture itself, response is characterized as instinctual or reactive as opposed to interpretive. Blumer (2004) writes:

In the conversation of gestures, the organisms in interaction respond to each other’s gestures without identifying the meaning of the gestures. Each organism responds unreflectively to the gesture of the other with an action already organized for release; the response is not preceded by, or based on, an interpretation of the gesture (Blumer and Morrione (Ed.), p. 89).

Social interaction on the basis of ‘conversation of gestures’ therefore, is a process that brings people together in interaction by implicating others and evoking a response.

Gestures become symbols when individuals interpret and respond to the gesture on the basis of interpretation (Blumer, 1969; Blumer & Marrione (Ed.), 2004). The distinguishing feature between conversation of gestures and the significant symbol is the process of interpretation. This process requires that the individual identify what a gesture signifies and then devise various kinds of responses to it. The defining characteristic of ‘significant symbols’ is that a symbol is part of a line of action that is picked out and interpreted to point to a larger act of which it is part (Blumer). In other words, the significant symbol belongs in the act. Underlying the act of ‘picking out’ a line of action is the notion of utility.

The second basic principle of pragmatist philosophy that pertains to the ontology of symbolic interactionism is that human beings define objects they encounter according to the perceived usefulness of the object (Charon, 1979; Crotty, 1998). In other words, reality as determined through the interpretive process of deriving and modifying meanings about symbols occurs on the basis of the utility of said meaning for dealing with situations of daily living encountered by the individual (Blumer, 1969). From this principle emerges symbolic interactionist assumptions that the meaning human beings attach to symbols (person, objects, situations) not only determines how they will act toward those things (Annells, 1996; Crotty; Lal, 1995), but also
affects the process used to handle and modify meanings in response to the situation encountered (Annells; Crotty). The interpretive process may include reflecting on past socialization and social interaction in relation to an object that reinforces old meanings and patterns of action or reflecting on current or future (imagined) interaction that, in turn, may give rise to new and creative meanings (Annells).

Although actors (individual, group) are active agents in defining and acting in response to their social environments, this is a reciprocal relationship in that both the actor and the environment (society) affect and are affected by the other (Charon, 1979). Charon writes: “We share with others a definition of the world and its objects...each time we interact with others we come to share a somewhat different view of what we are seeing” (p.54). It is, according to Charon, “this interaction that gives rise to our perception of what is real and how we are to act toward that reality” (p. 54). A key assumption of symbolic interactionism then is that reality can only be understood from this contextual, reciprocal relationship (Fine, 1993).

Since objects or symbols are assigned temporal meaning, that is meaning based on individual and social perceptions within past, present, and future contexts, symbolic interactionism also assumes the existence of multiple meanings or interpretations of reality. For the symbolic interactionist, the ‘self’ is a quintessential example of an object encompassing multiple meanings over time. In relation to the social nature and origin of self, Mead (1938) hypothesized that individuals enter into their own experiences as an object in experiential transaction with the social environment. Consequently, the definition of self is affected by one’s interpretation of the perspectives of society and social interaction with others in society.

One’s definition of self is also conceptualized and re-conceptualized through interaction with the “self” (Blumer, 1969). Interacting with the ‘self’ means that individuals have the ability to
communicate with and analyze the self. The reflective nature of self also allows a person to see him or herself as “object” (Blumer). Charon (1979) states: “The person imaginatively gets outside of his or her person and looks back on self as others do. This process depends to a high degree on taking the role of others, both significant others and reference groups, to see self from their perspective” (p. 79). In determining action or making choices, people determine those things or symbols that have meaning for them in a given situation through a process of reflection and self-communication. By virtue of this process of communication with self, interpretation becomes a matter of handling meanings (Blumer). By creatively grouping various meanings, new meanings are created that ultimately direct action. Obtaining individual perspectives and meanings, therefore, is critical to a research process which seeks to understand and describe how nurses, patients, and family members manage relationships when planning and providing care in acute care settings.

The concepts of process and time must also be emphasized in relation to symbolic interactionist’s view of reality (Charon, 1979). Symbolic interactionism assumes that all that is associated with being human (the individual, society, the mind, self, and truth) are not things but dynamic processes. Biological, structural, and cultural (e.g. roles, social expectations, norms, values) factors or constraints associated with any situation in which a human actor finds him/herself are taken into account in the course of determining action (Snow, 2001). Consequently, symbolic interactionism may be considered a theory of experience (Denzin 1992). Reality is judged by what is being observed and experienced; it is determined based on interaction with self and others at any given moment in history. While reality is organized in terms of time it is not static. Rather, reality is constantly transformed through a process of interaction as it occurs across time in relation to pasts, presents, and futures (Hall, 1987).
3.4 Epistemology

Two general pragmatist principles are reflected in symbolic interactionist assumptions related to the nature of knowledge. The first principle described by Charon (1979) is that "knowledge for the human being is based on its usefulness" (p. 29). Human beings learn and remember based on their judgments of how knowledge was useful in a given situation. Humans are thought to be continuously testing hypotheses related to ideas and action in various contexts and knowledge is refined or changed based on the outcome, result, or consequence (Charon).

The second pragmatist principle reflected in the epistemology of symbolic interactionism is derived in part from the objectivist orientation that asserts the position that what we know is determined by what we are able to observe (Anells, 1996; Denzin & Lincoln, 1998). For the symbolic interactionists, human or social action is the quintessential reference point to understanding both the individual and the group. As Charon (1979) maintained, it is from empirically observed human action that we are able to understand the human organism. However, symbolic interactionists also maintain what we know is more than what we observe or are able to see. In other words, to understand action one must infer meaning from the action (Charon). Inference of meaning about actors or between actors is generally based on consistency of action over time (Mead, 1938).

From the first epistemological principle emphasizing that knowledge is based on its perceived utilitarian value emerges several symbolic interactionist assumptions. First, knowledge is not a static concept. Knowledge is thought to be constructed and re-constructed through a process of social interaction (Crotty, 1998; Donmoyer, 1999). While constructionists maintain that meaning is derived from an interplay between object and subject, and subjectivists argue that meaning is imposed on the object by the subject based on perceptions derived from social
interaction, both positions rest on the symbolic interactionist assumptions that knowledge is socially situated (contextual), dynamic, and can only be understood through the perceptions of self and others (Ambert & Alder, 1995; Crotty). Actors come to understand the world through repeated transactions with it, therefore, knowledge is necessarily partial and provisional (Atkinson & Housley, 2003). Knowledge as it relates to symbolic interactionism is created through a process of interpretation of the world by which one is confronted. As such, knowledge takes the form of perception and meaning which in turn is used as the basis for directing human action. In describing the nature of human action, Blumer (1969) states:

...the human individual confronts a world that he must interpret in order to act instead of an environment to which he responds because of his organization. He has to cope with the situations in which he is called on to act, ascertaining the meaning of the actions of others and mapping out his own line of action in the light of such interpretation (p. 15).

Taken into account in this process of human interpretation are such practical factors as individual wishes and wants, objectives, available means for achievement of goals, actions and anticipated actions of others, self-image, past experiences, and the anticipated outcome of a given line of action (Blumer).

Central to the process of interpretation in which social actors are said to be engaged is one’s propensity toward self-knowing, self-consciousness, self-awareness, and self-communication or what Mead (1934) considered ‘possessing a self’. According to Blumer (1969), through exploration of self a human being becomes an object, like all other objects, of his own action. Blumer writes: “…he is an object to himself; and he acts toward himself and guides himself in his actions toward others on the basis of the kind of object he is to himself” (Blumer, 1969). Self in this instance is otherwise referred to as the ‘knower’ or what Mead referred to as the ‘I’. The ‘I’ occupies the position of the subject and is experienced as being in or ready for purposeful
action at any given moment (Blumer & Morrione (Ed.), 2004). The essence of the ‘I’ then is that part of the individual that is impulsive and spontaneous and provides a sense of initiative or propulsion to act (Charon, 1979).

Self is also viewed as a separate social object because the individual comes to see the self in interaction with others. In other words, one’s self is pointed out and defined socially (Charon, 1979). As object, self can be identified, judged, communicated with, directed, and manipulated. Charon commented that “individuals are able to act toward themselves in the same sense that they are able to act toward other objects pointed out to them in interaction” (p. 70). Self occupies the subjective position of that which is known or what Mead (1934) refers to as ‘Me’. The ‘Me’ experienced as object is viewed from the perspective of the community or generalized other (Blumer & Morrione (Ed.), 2004).

The complete self, according to Mead (1934), encompasses both the ‘I’ and the ‘Me’; each responds to the other in terms of viewing one’s self in action. The relationship between ‘I’ and ‘me’ is described by Mead as: The ‘I’ is the response of the organism to the attitudes of the others; the ‘me’ is the organized set of attitudes of others which one himself assumes. The attitudes of the others constitute the organized ‘me’, and then one reacts toward that as an ‘I’ (p. 175). The ongoing self-reports that result from the interaction between the ‘I’ and the ‘Me’ serve as the basis for self-evaluation, self-definition, and for guiding or controlling one’s conduct (Blumer & Morrione (Ed.), 2004; Lal, 1995; Reynolds & Herman-Kinney, 2003). One’s definition of self is also affected by imagination and imagination of self is influenced by available imagery (sources of mass media) which ultimately positions the self as an object in opposition to a socially constructed other (Lal, 1995).
The view that human beings possess a complete 'self' capable of thinking about and communicating or otherwise interacting with themselves, as they do with all other human beings, suggests that the notion of self is a process. Blumer argues: "The fact that individuals may indicate something to themselves and respond to their indication –or in other words communicate with themselves – signifies an ongoing process rather than a contemplative regarding of themselves as an object" (Blumer & Morrione (Ed.), 2004, p. 65). As a mechanism for self-interaction then, the essence of 'self' as process is considered to be cognitive in nature – an internalized conversation which constitutes thinking and reflective processes and takes the form of reflective knowing (Atkinson & Housley, 2003; Charon, 1979; Reynolds & Herman-Kinney, 2004).

With regard to the second epistemological principle that what we know is determined by what we are able to observe, the relationship between actor/ knower and what is known is based on actors’ interpretations of their interaction with the social world as a dynamic process (Crooks, 2001). In symbolic interactionist thought, knowledge is derived from interpretation of both overt and covert action. Overt action is seen as one’s manipulation of their environment. Covert action is that which is considered ‘mind’ activity, and the interplay between the two (Charon, 1979).

The notion of overt and covert action and the interplay between the two is best captured by Mead’s (1938) four stages of the act. In the stage of impulse, the actor experiences a state of disequilibrium which causes him/her to define self and the situation, which in turn is followed by an impulse or generalized inclination to act. This impulse does not in any way dictate the form or direction of the action, only that action of some sort will occur. Human beings are constantly experiencing various degrees of disequilibrium forcing them to actively respond to or deal with various aspects of their environment (Blumer & Morrione (Ed.), 2004; Mead, 1938). The
impulse stage sensitizes individuals to those environmental stimuli that are most relevant to them and prepares them for the furtherance or development of the act (Blumer & Morrione (Ed.), 2004).

The second state, perception, involves a more in-depth analysis of the situation. This process includes interpreting and defining environmental stimuli selected on the basis of their relevance to achieve specific goals and identifying lines of action. Determining a course of action also requires that the actor reflect on and consider both past and future actions thus incorporating knowledge in the form of memory and experience as well as foresight (Charon, 1979).

The third stage, manipulation, involves active manipulation of the environment. This stage is considered to be the overt phase of action because of the purposeful manner in which the actor responds toward objects in an effort meet identified goal(s) (Charon, 1979). Finally, the stage of consummation (if it occurs) signifies the restoration of tentative equilibrium – tentative in the sense that it is only achieved and/or maintained in the absence of other act sequences that result in a constant stream of action (Charon).

As a social process, human action incorporates both covert and overt phases of action construction (Charon, 1979). Covert action relates to stages involving defining the self and the situation and establishing goals and determining lines of action. Overt action involves the manipulation of the environment to achieve identified objectives aimed at restoring equilibrium or, in other words, managing with the situation in which one finds him or herself. As mentioned previously, the symbolic interactionist view of human meaning and action has implications in terms of how human interaction is understood. Similarly, it has implications for how human action is or ought to be studied.
3.5 Methodology

Methodology represents the principle ways in which researchers act on their environment (Denzin, 1989). Methodology is, however, contextual. Methodology is selected and implemented based on the philosophical stance or theoretical perspective that lies behind the choice (Crotty, 1998). Theory, according to Denzin, provides “order and insight to what is or can be observed” (p. 4). Methodology also provides rationale for the choice of research methods and the form in which the methods are employed in terms of yielding data that represent different features of reality and make the research public and reproducible by others (Crotty; Denzin).

As discussed previously, symbolic interactionists maintain that reality exists in the empirical world and is to be discovered in the examination of that world (Blumer, 1969). Knowledge is believed to arise from and be based on principles of exploration and interpretation (Blumer; Atkinson & Housley, 2003). Scientific knowledge is “understood not in terms of abstract philosophical prerequisites, but in terms of human engagement with the world about us” (Atkinson & Housley, p.122).

Symbolic interactionism is a practical approach to scientific study in which scientific methods are considered mere instruments designed to identify and analyze what is actually going on in real life, particularly in terms of reflecting human interpretation of the empirical world (Blumer, 1969). As an empirical science, therefore, it is important that symbolic interactionism respect the empirical world under investigation by fitting its problems, guiding conceptions, procedures of inquiry, techniques of study, and theories to that world (Blumer). Ultimately, the symbolic interactionist perspective guides research activities in such a way that they “yield verifiable knowledge of human group life and human conduct” (Blumer, p. 21) or in the words of Denzin (1992): “make the world of lived experience directly accessible to the reader” (p. XIII).
Of central methodological importance in examining the empirical world from a symbolic interactionist perspective is the 'act' or 'action' itself. Since action is comprised of observable properties, empirical research techniques applied to the actual social setting are of some use in capturing qualities of human behavior (Blumer, 1969). As mentioned previously, however, symbolic interactionists maintain that action is also comprised of covert qualities – that is human behavior in relation to self and others occurs in a given context that can neither be observed nor predicted with any degree of certainty. Consequently, observational techniques alone may be limited by the lack of meaning they are able to convey.

To grasp the meaning of human action, the symbolic interactionist perspective requires the use of methods that are amenable to observation of overt behavior, as well as those approaches that promote understanding about the thinking processes that direct action. As argued by Charon (1979), the researcher employs methods that promote understanding about the manner in which people come to define actual situations, how they develop and use perspectives, change perspectives, role-take, apply their past, problem solve, converse with self, and decide on a line of action. In short, investigators must seek to examine the everyday world as it is lived and experienced by the actor or actors.

The everyday world or 'empirical world', according to Blumer (1969), constitutes the actual group life of human beings as defined by what actors individually and collectively experience and do. Blumer states: "the life of human society or of any segment of it or of any organization in it or of its participants consists of the action and experience of people as they meet the situations that arise in their respective worlds" (p. 35). Hence, the empirical world represents all aspects of human life and society. Although it is important to take into account social structures in terms of how they influence human perceptions and behavior, because symbolic
interactionism emphasizes social process as opposed to social structure, study of the empirical world necessarily incorporates the relation between presents, pasts, and futures (Hall, 1987; Lal, 1995).

Returning to the goal of understanding human action, researchers must set their aims to understand how humans act in the present by applying past experience and future plans. Charon (1979) described the interrelationship between past, present, and future as being integral to the individual’s ability to define the situations they face. The past, described by Mead (1938) as ‘experience’ in the form of memory, and ‘hypothetical’ future (one’s plan) does not dictate human action, but both are considered in the process of undertaking action. This implies that symbolic interactionism as a scientific perspective must strive to explain the cause of human action - that is, how individuals think and define situations; how present actions are affected by past experiences and future plans; how they define and respond to others; and how they solve the problems or situations which confront them (Charon). Consequently, while observation in real settings is important, incorporating data collection methods that employ direct communication (such as semi-structured interviews) is critical to obtaining the emic perspective (Morse & Field, 1995), or, in the case of a study examining how participants manage relationships, ‘getting inside the heads of nurses, patients, and family members. Dialoguing directly with participants will enable me to become more aware of their perceptions, feelings, and attributes, which will enhance my ability to interpret their meanings and intent (Crotty, 1998). Mead captures the importance of dialogue to the research process as follows” “Observation, hypothesis, and experiment lie…in the biographies of the individual…and so does the emphasis of attention which marks analysis and the process of so-called logical thinking” (p.67).
To fully grasp the other's perspective, the investigator is compelled to take, to the best of his/her ability, the standpoint of those being studied or to put oneself in the place of the other (Crotty, 1998). This action requires a commitment to not only actively enter the world of interacting individuals but to do so as freely as possible with minimal preconceptions, assumptions, or a priori hypotheses (Denzin, 1989). By putting one's own perspective on 'hold' the researcher is better positioned to capture the voices, emotions, and actions associated with the lived experience of others and to strive to understand the meaning that people assign to the situations they encounter and the ways in which meaning ultimately guides action (Crotty; Denzin, 1989; Denzin, 1992).

Finally, given that symbolic interactionism emphasizes social human action as processual in nature, the researcher must employ strategies that promote understanding of the dynamic and contextual characteristics of social organization and its influence on human interaction. This means not only taking into account the many layers of contextual and perceptual aspects of reality but also acknowledging its dynamic quality (Mead, 1938). Methodologically then, incorporating strategies that take into account the contextual and systemic characteristics of the environment, such as participant observation in various acute care settings, would be important to the process of understanding how such factors affect nurses' practice and patients' and families' efforts to manage relationships. Moreover, implementing strategies aimed at seeking to understand how participant behavior fits or does not fit with their articulation of meaning associated with contextual and systemic characteristics within the environment is also critical.

The dynamic nature of human social action also speaks to the symbolic interactionist view that knowledge, as in the case of scientific findings, is also dynamic. Mead (1938) captures this idea when he states:
The fundamental assumptions involved in the account of knowledge that I am presenting are: that it is a process of finding something that is to take its place in a world that is there, which world that is there is the presupposition of the undertaking that we call “knowledge”: that the world that is there is a temporal world i.e., that it is continually passing,...that the world is therefore continually ceasing to be as it passes into the world of the following moment...(p. 64).

The goal of symbolic interactionist research, therefore, is the development of modifiable theories about human social interaction patterns that rest on the behaviors, definitions, meanings, and attitudes of those studied (Denzin, 1989). In explaining how nurses working in acute care hospital settings and patients and family members manage relationships when providing care, it would be important for me to account for variables, such as individual meaning and perception, personal factors, and contextual and systemic conditions that affect interactive patterns over time.

3.6 Summary

As a theoretical perspective on life, society, and the world, symbolic interactionism directs interpretive research in a way that focuses on the meaning of basic social interaction from the perspective of the actors. Strongly influenced by pragmatist philosophy, which maintains that people are emergent beings engaged in ongoing, active interaction with their environment, symbolic interactionism rests on three main premises related to human action. The premises are as follows: (1) people individually and collectively act based on the meaning they assign to symbols or objects in their life; (2) the meaning of symbols is derived from or arises out of social interaction; (3) meanings are perceived and modified through a process of interpretation.

Symbolic interactionism emphasizes the importance of exploration and interpretation of human engagement in the empirical world. The empirical world is considered as all aspects and contextual layers of what actors individually and collectively experience and do as they confront the situations that arise in their respective worlds. Symbolic interactionism, therefore, supports
exploration and interpretive analysis of experiences, actions, and variations across time and context in natural settings. I am directed to employ methods that promote understanding about how people define actual situations, assign meaning and develop and use perspectives, role-take, problem solve, converse with self, decide on a line of action, and act. Given that my primary research goal, as guided by symbolic interactionism, is to obtain and describe others’ perspectives and behaviors with regard to social interactive processes, I will use methods such as observation, reflection, interaction and dialogue in naturalistic settings. Thus, the strategy of inquiry employed in this study is the grounded theory method which will be described in-depth in chapter four which follows.
CHAPTER FOUR

4 Strategy of Inquiry: Grounded Theory

The purpose of this chapter is to describe the strategy of inquiry employed in this study. The strategy of inquiry connects the theoretical perspective of a study to a particular research design which in turn guides the choice and use of specific methods for collecting and analyzing data to achieve a desired outcome (Crotty, 1998; Denzin & Lincoln, 2000). The primary goal of grounded theory guided by symbolic interactionism is to explain social interactive processes. A detailed account of the grounded theory method, sampling, ethical considerations, recruitment, data collection, data analysis, and rigor will be described in this chapter.

4.1 Grounded Theory as Informed by Symbolic Interactionism

Symbolic interactionism is widely cited as the theoretical foundation or perspective upon which grounded theory is based (Benoliel, 1996; Hutchison & Wilson, 1993; Morse & Field, 1995). As previously discussed, symbolic interactionism is concerned with understanding people's behavior from their perspectives. Their behavior is influenced by social interactions, interaction with self, and the socio-cultural environment or context in which they live. Grounded theory as informed by symbolic interactionism, therefore, aims to represent the complex interactional processes as theoretical explanations that are inherently relevant to the practice world from which they emerged (Hutchison & Wilson).

In the tradition of interpretivist philosophy, grounded theory researchers who use the symbolic interactionist perspective regard knowledge as influenced by temporal, socio-cultural, and subjective conditions, which inform multiple symbolizations of reality. Consequently, the social and interpersonal context of the actors, as well as their intentionality and conscious construction of meaning as expressed through symbols and social interactions, is of central
concern (Benoliel, 1996). Based on the importance of seeking meaning and understanding from the actor's point of view, it is critical that the grounded theorist enter the field with as few predetermined ideas or prior hypotheses as possible. The researcher's mandate is to remain open to what is actually happening as opposed to filtering or framing data (at all stages of collection and analysis) through his or her biases (Glaser, 1978). As stated by Glaser "The goal of grounded theory is to generate theory that accounts for a pattern of behavior which is relevant and problematic for those involved" (p. 92).

Central to the grounded theory method informed by symbolic interactionism is the assumption that interpretations of reality are socially constructed. Two key implications of this assumption are that a) people sharing common circumstances likely share a specific psychosocial problem that may not necessarily be articulated and, b) in response to this common problem people order and make sense of their environments (Hutchison & Wilson, 1993). The aim of grounded theory research, therefore, is to develop core variables that explain patterns of behavioral responses to a main concern or problem actors try to manage in particular social settings.

For this study, the goal was to understand and explain individual and collective perceptions of and patterns of actions/behaviors of nurses, patients, and family members as they manage relationships during care giving within a specific context - the acute care hospital setting. Since little is understood about nurse-patient-family relationships as they develop and evolve in contemporary acute care settings, grounded theory was an appropriate means of inquiry. When little is known or understood about a topic, grounded theory is particularly useful because it focuses on analysis of everyday meanings and patterns of behavior to generate theoretical explanations (Dempsey & Dempsey, 2000; Glaser, 1978; Hutchison & Wilson, 1993). Capturing
meaning in order to explain behavioral patterns of a specific group directs the investigator toward methods of seeking actors' interpretations or meaning-making in terms of personal, relational, and contextual features – a hallmark of symbolic interactionism.

4.2 Grounded Theory - An Overview

Grounded theory is a research method that is used to systematically generate theory from data (Glaser & Strauss, 1967; Glaser, 1978). The study design is intended to identify social problems and the social-psychological and social-structural processes that arise as humans adapt to situations in which they find themselves (Benoliel, 1996; Crooks, 2001). Morse and Field (1995) asserted that the primary goal of grounded theory is to explain human behavior.

Barney Glaser and Anselm Strauss described grounded theory in 1967. According to these authors, substantive theories are considered 'grounded' because they are systematically developed through a process of data collection from multiple sources, theoretical sampling to develop and refine emerging categories, and constant comparative analysis that occurs simultaneously with data collection. As a result, hypotheses and concepts that make up the theory are constructed from the data (Glaser & Strauss, 1967).

Data are collected in natural settings using techniques such as semi-structured interviews and participant observation. Analysis focuses on meanings, experiences, and context. The analysis generally produces a core variable as well as codes, concepts, categories, and hypothesized relationships among categories. The core variable often represents a social process that offers a tentative explanation of the phenomenon being studied (Hutchison & Wilson 1993; Jacelon & O'Dell, 2005). In short, "the process [of grounded theory], generates theory that fits the real world" (Glaser, 1978, p. 143).
Since its inception, grounded theory has developed in diverse ways (Benoliel, 1996; Boychuck & Morgan, 2004; Denzin & Lincoln, 2000; Heath & Cowley, 2004). Most notably, the difference in opinion that evolved between Glaser and Strauss resulted in what is now commonly regarded as two different typologies of grounded theory methods: the Glaserian model and the Straussian model (Stern, 1994). While it is not within the scope of this chapter to recount the details of what Melia (1996) refers to as “a head on clash between Glaser and Strauss”, it is important that when using grounded theory I declare my interpretation of grounded theory which I chose to guide my research, which is the ‘Glaserian’ model.

The divergence of opinion between Glaser and Strauss and Corbin became public with the release of Glaser’s book *Emergence vs. forcing in basics of grounded theory analysis* (1992). In this text, Glaser expressed his objections to Strauss and Corbin’s (1990) representation of grounded theory; his objections spawned the ongoing debate over which method captures the essence of grounded theory (Hutchison & Wilson, 1993). While Strauss and Corbin argued that they have refined the grounded theory method by providing a more straightforward approach to data analysis (Hutchison & Wilson), Glaser (1992) maintained that Strauss and Corbin’s version is not grounded theory but full forced conceptual description. At the heart of the debate lies procedural differences between the Straussian and the Glaserian model that center on differences in data analysis (Heath & Cowley, 2004; Melia, 1996). What follows is a brief overview of three main methodological points of departure between Glaser and Strauss and Corbin.

The first point relates to the nature of the research question. As described by Melia (1996) and Heath and Cowley (2004), Strauss and Corbin considered the research question to be a statement that identifies the phenomenon to be studied and what is known about the subject. Glaser (1978; 1992) on the other hand, argued that the research question should emerge and evolve as data are
collected and analyzed rather than being predetermined. The notion of emergence follows from Glaser’s commitment to the importance of theoretical sensitivity, or in other words, the analysts’ ability to ‘remain open to what is actually happening’ (1978, p 3).

While Glaser and Strauss both agreed that prior understanding of the general problem area contributes to one’s ability to be open to a wide range of possibilities, Strauss maintained that both theoretical sensitivity and the process of generating hypotheses can be stimulated through initial and purposeful use of both the self and the literature, without introducing researcher bias (Heath & Cowley, 2004). Contrary to Strauss’ position, Glaser (1978) stressed that, in order to remain open to the data, it is important to enter the research setting with as few “logically deducted, a prior hypotheses as possible” (p.3). Glaser argued that literature should be incorporated later in the process once the theory is considered sufficiently grounded and developed. At that point the literature is considered to be “…part of the data and memos to be further compared to the emerging theory to generate even more dense [sic], integrated theory of greater scope” (Glaser, p. 7). Glaser further argued that, in order to remain open to the emerging theory, the researcher ideally begins with a sociological perspective about a general problem area. I agree with Glaser that such a perspective could take the form of “some combination of a clear question or problem area in mind, a general perspective, and a supply of beginning concepts and field research strategies” - an approach that, while somewhat limiting, is still receptive to the emergent (p. 45).

The second point generally relates to the process of data analysis, particularly as it pertains to initial coding. Strauss and Corbin advocated a more mechanical, highly structured procedure of breaking down and conceptualizing the data, for example, axial coding operations (Melia, 1996). Glaser promoted theoretical coding techniques that involve analytic processes such as constant
comparison of incidents and concepts within the data for the purpose of identifying similar patterns of incidents that can be categorized (core categories and basic social processes) until saturation occurs (Boychuk Duscher & Morgan, 2004; Glaser, 1978; Heath & Cowley, 2004). There is also contention about the end product, that is, whether theory is forced or generated (Heath & Cowley). Boychuk Duscher and Morgan captured this point when they wrote: "Glaser’s contention that Strauss and Corbin’s questions are highly structured, reductionistic, and intrusively deconstructive in nature is fundamental to his allegation that they force a full conceptual description of the data rather than articulate emergent theory" (p. 608). I support Glaser’s criticism that claims the Straussian approach forces data to fit preconceived conceptual categories as opposed to letting the data ‘speak for itself’ (Glaser, 1978; Glaser, 1992).

4.3 Research Design

4.3.1 Purpose.

As previously stated, I used the ‘Glaserian’ model for my study. By the ‘Glaserian’ model, I refer to the model of grounded theory first described by Glaser and Strauss (1962) and later elaborated by Glaser (1978) - informed by the theoretical perspective of Symbolic Interactionism. The ultimate goal of this study was to construct a core category that explains the general phenomenon under investigation - namely, the nature of managing relationships between nurses, patients, and family members in the acute care hospital setting. A core category represents the main theme associated with the primary problem of people in the setting under investigation and explains, by summing up in a pattern of behavior, what is going on in the data (Glaser, 1978). In order for a theme to be classified as a core category it must meet the following criteria: it recurs frequently; it maintains a position of centrality by explaining much of the
variation in the data; it relates meaningfully and easily to other categories; it takes longer to saturate, and; it has clear implications for formal theory position (Glaser, 1978).

A core category may take the form of a basic social process (BSP) – the main difference between a core category and a BSP being that a BSP is “processural”, meaning that is has two or more clear emergent stages (Glaser, 1978). According to Glaser “BSP’s…are fundamental, patterned processes in the organization of social behaviors which occur over time and go on irrespective of the conditional variation of place” (p. 100). As Benoliel (1996) explained, interpretation of a basic social process results in an explanation of the phenomenon being studied and provides the core of a substantive theory. Basic social processes are further categorized as basic social psychological processes (BSPP) and basic social structural processes (BSSP), although the two forms of categories are interrelated. Basic social structural processes represent a set of structural conditions that constrain, facilitate, or simply create the social structure under which social psychological processes occur (Glaser). Generally, basic social psychological processes (BSPPs) are implied by basic social processes (BSPs); when generating a social structural process, however, the researcher must clearly state it as such by using BSSP (Glaser). Depending on the nature of the emerging theory, the basic social process may emphasize the BSPP, the BSSP, or both.

4.3.2 Questions.

Three research questions, which reflected a broad perspective about acute care nurse-patient-family relationships, were developed to guide this study. Given that the main purpose of the study was to explain how nurses, patients, and family members managed relationships when providing care in acute care hospital settings, these research questions focused on structural,
processual, and interactional features of nurse-patient-family interactions from the perspective of participants. The specific research questions were stated as:

1. How do nurses, patients, and family members perceive their management of relationships in order to plan and provide patient care in the acute care hospital setting?

2. How do contextual and systemic features or structural conditions affect nurses’, patients’, and family members’ efforts to manage relationships to plan and provide patient care?

4. How do personal factors affect nurses’, patients’, and family members’ perceptions of their efforts to manage relationships to plan and provide patient care?

The questions were based on my sensitivity to terms such as collaboration and decision-making which have been associated with nurse-patient-family relationships. These sensitizing concepts proved to be irrelevant based on the ‘local’ concepts (those used by participants) that began to emerge. I modified my questions during the study to stay open to the data (Glaser, 1978).

4.3.3 Initial purposive sampling.

A key feature of the grounded theory method for data collection and interpretation is the recursive, process-oriented analytic procedure characterized by constant comparison and theoretical sampling (Greene, 1998; Locke, 1996). Constant comparison involves the process of comparing and contrasting “every piece of relevant data with every other piece of relevant data” for the purpose of identifying patterns or instances of phenomenon that seem similar or dissimilar (Morse & Field, 1995, p. 158). Theoretical sampling, which is based on collecting, coding, and analyzing data, refers to making decisions about which data should be collected next to develop the theory as it emerges (Dey, 1999; Glaser 1978; Kendall, 1999).

Since the emerging theory guides the participant selection process, it is impossible for the researcher who uses theoretical sampling to know in advance precisely what to sample for and
where it will lead him/her (Glaser, 1978); however, the researcher has to start somewhere. Consequently, Glaser maintained that initial decisions must be made on the basis of a general sociological perspective about the substantive area as opposed to a preconceived problem or hypothesis. Such a process requires the investigator to begin with purposive sampling.

Purposive sampling, which occurred at the initiation of my grounded theory study, was based on a general sociologic perspective about a substantive area which takes the form of a somewhat limited framework of related or “local” concepts (Glaser, 1978; Glaser & Strauss, 1967). At this stage, I purposefully selected participants from the field of inquiry based on their willingness and ability to generally speak to the phenomenon of interest as specified by Glaser. My initial purposive sampling decisions influenced the selection of participants who were involved in particular incidents, events, and activities in particular settings.

As I collected, coded, and analyzed the data, I shifted the conceptual framework to reflect what was happening in the data and then selected participants based on the contribution they were likely to make to the emerging theory. According to Morse (1999) “it is this process of selecting that ensures that the theory is comprehensive, complete, saturated, and accounts for negative cases” (p. 5). I continued purposive sampling and constant comparison of data until beginning categories began to emerge.

Since the goal of my research study was to explore how nurses, acute medical/surgical patients, and their family members managed their relationships with each other during the provision of care, I designed my sampling to include each of these groups (nurses, patients, and family members) from medical, surgical, transitory care, and intensive care units. Although I initially planned that recruitment would occur from nursing units within three community hospitals in the Fraser Health Authority of British Columbia, I later obtained permission to
expand recruitment to include two additional hospitals within the region. Due to saturation and constraints associated with my dissertation, I only sampled from four of the five hospitals.

Although I considered obtaining data from nurses, patients, and family members interacting simultaneously around patient care as ideal, I anticipated and ultimately confirmed that the unpredictability of family visits and the complexity of acute care settings would make obtaining data from interacting groups of nurses, patients, and family members very difficult. Consequently, I collected data from nurse, patient, and/or family member participants who were independent of each other. In other words, I asked nurses to speak about their general experience and perceptions about managing relationships between themselves and patients and family members when planning and providing care. Similarly, I interviewed patients and family members about their general experiences and perceptions while managing relationships with nurses. When I asked participants to reflect on their experiences and perceptions, I asked them to refrain from revealing information that would disclose the identity of the nurse(s), patient(s), and/or family member(s) discussed. I based inclusion criteria for participation on the nature of the particular acute illness experienced by the patient by considering its documented prevalence within acute care hospitals in Canada, average length of hospital stay, and life threatening/life altering effect of the illness for patients and family members.

4.3.4 Inclusion/exclusion criteria for patient participants.

I identified initial purposive sampling criteria as adult patients (defined as being 19 years and over), admitted to one of four community hospitals within the Fraser Health Authority of British Columbia, Canada, with a diagnosed acute illness episode. I based determination of an acute illness episode on the Canadian Institute of Health Information (2002) report of diagnoses most likely to result in acute care hospitalization across Canada in 1999/2000 and the British
Columbia Ministry of Health Planning (2002) report on the increased incidence of respiratory related diseases, unintentional injuries, colorectal cancers, and diabetes. Thus, I considered diagnoses to be acute illness episodes when they were: cardiac disease such as heart attack or cardiovascular accident (stroke); respiratory disease including lung cancer; digestive disease including stomach, gastrointestinal or colorectal cancers; other cancers considered to be in an acute stage of initial diagnosis or recurrence e.g. leukemia; unintentional injury such as falls or motor vehicle accidents; and/or acute complications associated with metabolic or other diseases, such as diabetes. While the disease-specific length of stay statistics indicated that the average minimum length of stay for an acute illness ranges from 5.5 days for respiratory diseases to 9.5 days for malignant and benign cancers (Canadian Institute of Health Information), the actual length of stay for acute illness may be substantially less. Since I was concerned with understanding and describing how nurses, patients, and family members manage relationships, which occurred over time, I excluded patients and family members of patients hospitalized for less than twenty four (24) hours from the sample. I also excluded patients who were unconscious, semi-conscious, or otherwise unable to communicate verbally for reasons associated with disability, medication, treatment, and language barriers. If I interviewed a patient who was independent of any particular patient-nurse-family member triad or dyad, I asked him or her to reflect on his or her interactions with nurses, and between family members and nurses in which he or she participated.

4.3.5 Inclusion/exclusion criteria for nurse participants.

I included nurse participants who were registered with the College of Nurses of British Columbia and employed by one of the community-based hospitals located within the Fraser Health Authority of British Columbia, Canada. These nurses were employed on a full or part-
time basis on the participating medical, surgical, transitory, activation care, or intensive care units. In order for a nurse to meet my qualifications for being interviewed about managing relationships in the nurse, patient, and family triad, he or she must have been assigned to that patient for a minimum of (not necessarily consecutive) sixteen hours or the equivalent of two-eight hour or 1.3 twelve-hour shifts. If I interviewed a nurse participant who was independent of any particular patient-family triad or dyad, I asked him or her to reflect on interactions, in general, with patients and family members, to whom she or he had been assigned for at least the period of time stipulated. Registered nurses who were employed by the hospital on a contract or casual basis were not eligible to participate in the study. I also excluded registered psychiatric nurses, licensed practical nurses and other 'nurse' designations, such as nurse managers.

4.3.6 Inclusion/exclusion criteria for family member participants.

I included family participants who were 19 years or older and identified by the patient, the nurse caring for the patient, or self-identified as a primary source of support for patient care planning and/or delivery. In cases where more than one family member was identified, I included multiple family members in interviewing. If I interviewed a family member who was independent of any particular patient-nurse triad or dyad, I asked him or her to reflect on his or her interactions with nurses and family members who had been patients. I excluded family members who were unable to communicate verbally for reasons associated with disability and/or language barriers.

4.4 Ethical Considerations

Initiating and maintaining trust with participating agencies and research participants is the primary focus of any research study involving human beings (Morse & Field, 1995). Trust as a moral imperative requires that the researcher attend to the three ethical principles associated with
informed consent: respect for human dignity, beneficence, and justice (Fontana & Frey, 2000; Morse & Field).

The principle of respect for human dignity addresses a person's right to self-determination and full disclosure. In the context of research involving human subjects, this means that participants have the right to be fully informed about the nature and consequences of the experiments or studies in which they are involved (Christians, 2000). Both the agency and the subjects must be provided with an understandable and sufficiently detailed verbal and written explanation, including risks and benefits of the study and how they will be involved. The notion of self-determination means that subjects must agree to participate on a completely voluntary basis, free from physical or psychological coercion (Dempsey & Dempsey, 2000), and they have the right to withdraw their participation from the study at any time without penalty or consequence (Morse & Field, 1995).

The principle of beneficence relates to the right to freedom from harm and exploitation (Dempsey & Dempsey, 2000). The researcher must treat participants in a way that conveys respect and make every effort to protect their well being. Christians (2000) extends the notion of exploitation to mean opposition to deception that is considered deliberate misrepresentation. In other words, the researcher must not, under any but the most extreme circumstances deliberately misrepresent any aspect of the study.

The principle of justice involves the right to be treated in a fair and equitable manner, as well as the right to privacy (Dempsey & Dempsey, 2000). Confidentiality is of extreme importance and must be ensured to protect the participant and the agency from unwanted exposure. This means that the investigator must ensure that the identities of participants will not be disclosed other than in the confines of the consent agreement. The principle of justice also requires that the
benefits of the research must be accessible and applied equally to all members of society (Dempsey & Dempsey; Liaschenko, 1999).

Because protecting the rights of participants is of critical importance, I implemented initiatives to address the principles of human dignity, beneficence, and justice in this study. I began with securing ethical approval and any extensions from various governing bodies associated with the study. I then negotiated access and obtained informed consent. I now present an overview of these measures and associated issues.

4.4.1 Obtaining ethical approval.

In compliance with the Faculty of Graduate Studies at the University of British Columbia (UBC), I sought ethical approval from the University of British Columbia Behavioural Research Ethics Board (Appendix A - Certificate of Approval), the Fraser Heath Authority (Simon Fraser Area) Clinical Investigation Committee (Appendix B), and the South Fraser Health Authority Regional Research Review Committee (Appendix C), prior to commencing my study. During the course of data collection, the two regional health authorities merged to form the Fraser Health Authority. Obtaining ethics approval from the appropriate governing bodies is a necessary measure to protect the rights of participants as it requires that the research protocol, including documents such as the information letters used to describe the study and participant rights (Appendix E), consent forms (Appendix F), and demographic questionnaires for nurses (Appendix G), family members (Appendix H), and patients (Appendix I) be reviewed and accepted. I obtained ethical approval from the University of British Columbia Behavioural Research Ethics Board for a one year term commencing November 2003. The South Fraser Health Authority Regional Research Committee and the Fraser Health Authority (Simon Fraser Area) Clinical Investigation Committee granted approval in October 2003.
4.4.2 Ethical approval extension.

I encountered several common delays associated with the process of negotiating access and commencing recruitment, including difficulty making contact with administrators due to vacation and work demands. The most significant barriers included the closure of a community hospital in the early spring of 2004 followed by the Health Employees Union (HEU) job action that began in the late spring of 2004. Both events resulted in considerable disruption to nursing units and the hospitals where I planned recruitment, which meant further delays in negotiating entry to the field. Consequently, the recruitment period extended beyond the approved twelve month period and an application for extension became necessary. Since data collection had been completed at the South Fraser Health Authority site (N= 4 sites), I submitted and received a request for extension from the University of British Columbia Behavioural Ethics Review Board (Appendix A) and the Fraser Health Authority Clinical Investigation Committee (Appendix B).

4.5 Procedures

4.5.1 Negotiating access.

I negotiated and renegotiated access to the field. Negotiation and renegotiation includes such issues as where, when, and with whom the research study will take place (Morse & Field, 1995). To negotiate entry to each site I telephoned and/or made e-mail contact with the hospital administrator and submitted ethical approval certificates and an information letter and consent form. I obtained permission from administrators to contact nursing unit managers. I contacted managers via telephone and/or e-mail and provided information letters and consent forms.

I met with unit managers to discuss my specific unit access and recruitment needs. The unit managers identified units under their supervision that provided care for the patient categories outlined in my inclusion criteria with regard to admitting diagnoses. After identifying
appropriate units, the managers informed the patient care coordinators about the study, requested that they cooperate with me, and provided me with patient care coordinator contact information. I contacted patient care coordinators to discuss details of the study, such as specific recruiting strategies, and to enlist the assistance of their staff nurses, nurse educators, and unit clerks.

4.5.2 Participant recruitment strategies.

Once I obtained access, I began recruiting nurses, patients, and family members. In keeping with the right to self-determination – that is the right of prospective participants to decide voluntarily whether to participate in the study without risk of penalty or prejudicial treatment (Loiselle & Profetto-McGrath, 2004), I avoided any form of coercion when distributing information about the study and an invitation to participate. Given the possibility that I could be perceived as having authority over potential participants, I requested staff nurses or patient care coordinators on the unit to distribute information letters (Appendix E) and/or otherwise inform peers, patients, and family members about the study. Those employees ensured that potential participants received information letters so that they could read them at their convenience. The information letter provided details about the study including: information about the principal and co-investigator, the purpose of the study, study procedures, participants’ rights, and contact information should participants have any concerns about the study. Upon receipt of the information letter, participants initiated contact with me. Individuals who decided they were interested in participating or required further information or clarification contacted me to set up a meeting.

I found that recruitment was slow when patient care coordinators and staff nurses forgot to distribute the information letters to patients and family members. On some occasions when potential participants received the letter and indicated interest, staff members did not follow up.
After several follow-up calls to the units failed to yield any participants, I made adjustments to the recruitment approach.

Upon consultation with the patient care coordinators I decided that information letters would be distributed to patients (who met the criteria), family members, and nurses during times when I was on the unit. This arrangement allowed me to be immediately available to meet with potential participants who expressed an interest in being interviewed or wanted more information. Decreasing time between receiving the letter and initiating direct contact with me accelerated the recruitment process and increased my chances to secure participants.

I planned my availability in order to avoid ‘busier’ times on the unit, such as early mornings, and late afternoon when patients were typically napping. Nurses tended to have more free time in the early afternoon, family members were more likely on the unit, and patients were more likely awake and available to talk. In the case of nurses who wished to participate, the hospital, through the efforts of the unit manager and/or patient care coordinator, provided coverage so that the participant nurse could be freed from her (all nurse participants in this study were female) duties - in some cases for up to forty-five minutes.

To confirm participation in my study, I obtained informed (written and verbal) signed consent (Appendix F). Because I provided a detailed information letter and a consent form that reiterated the nature of the study and rights of participation and reviewed these documents verbally with individual(s), I maintained the requirement of full disclosure. Participants who gave informed consent retained the right to withdraw from the study at any time without question. Of the forty participants (N = 40) recruited, none withdrew from the study and I received no complaints about the study or study procedures.
I maintained confidentiality by omitting participant names or any other identifying information (e.g. diagnosis, hospital) on audio-tapes or any study documents other than the consent forms which required a signature. I identified audio-tapes and documents by using a letter/number combination (2 digit code) and kept all documents and tapes in a locked filing cabinet. I protected computer data with a password.

During data collection, I respected confidentiality by conducting interviews in areas that were quiet, free from distraction, and as private as possible. Most interviews were conducted in an interview/conference room adjacent to the nursing unit(s). If such a room was not available or patient participants could not leave their beds, I conducted interviews in patient rooms. In most cases, the patient and/or patient and family member were the only ones in the room at the time of the interview. In the small number of cases where the room was shared with others, the other patient was out of the room or appeared to be sleeping. I drew the patient participant’s curtain to provide privacy and spoke softly to prevent the conversation from being overheard.

4.5.3 Data collection.

I obtained data for this study from a total of forty participant interviews with patients (N = 13), nurses (N = 17) and family members (N = 10). While the majority of participants were interviewed individually, nurse participants N-04 and N-05 were interviewed together, as were family members F-05 and F-06. As well, on three occasions a patient and family member participant were interviewed together. I not only transcribed each interview, but also captured my thoughts, impressions, and observations about them in field note data. In addition, I undertook a total of thirty-three hours of participant observation and wrote field notes describing those experiences.
Theoretical sampling guided my data collection process. According to Glaser (1978), theoretical sampling is itself a process "whereby the analyst jointly collects, codes, and analyzes his [her] data and decides what data to collect next and where to find them, in order to develop his [her] theory" (p. 36). Critical to this process is that data are collected on the basis of a general sociological perspective about an area of interest or concern about a population (Glaser; Glaser & Strauss, 1967). While predetermination of the direction that data collection will take in grounded theory research is not possible or even desirable, initial data collection strategies were aimed at identifying a partial framework of 'local' concepts about the social organization and action under consideration, as suggested by Glaser, (1978).

Theoretical sampling requires a multi-faceted investigation in which there are "no limits to the techniques of data collection the way they are used, or the types of data acquired" (Glaser & Strauss, 1967, p. 65). Glaser and Strauss argued that flexibility in the form of data and methods used to collect them is especially important when the researcher must work around the structural conditions (schedules, restricted areas, and varying individual perspectives) of groups. Also, they argued that the more 'slices of data' obtained, that is, the more data collection techniques used, the richer the information will be and the more depth the emerging categories will have (Glaser & Strauss). Data collection is primarily intended "to gather extensive amounts of rich data with thick description" (Charmaz, 2000, p.514).

Although I anticipated that the focus of data collection and the strategies to obtain data would evolve on the basis of the emerging theory, I used general techniques for data collection which included: a demographic data questionnaire, semi-structured audio-taped interviews; participant observation, and field notes. I used journaling to capture my personal reflections throughout the
process. I will provide a brief description, including the implications of each form of data collection.

### 4.5.4 Descriptive data.

I developed questions to capture participant demographic information such as gender, age, marital status, level of education, and cultural identity. These data provided a description of the sample and evidence that participants met the inclusion criteria (e.g. professional designation, age, reason for hospitalization, length of stay). These data permitted me to discuss the representativeness and transferability of findings to similar populations (Dempsey & Dempsey, 2000). I summarized the data with frequency distributions or means and standard deviations.

### 4.5.5 Semi-structured interviews.

A semi-structured interview strategy is utilized when the researcher has identified main questions but the answers are unpredictable (Morse & Field, 1995). When using the semi-structured interviewing, researchers prepare a conversational guide (Rubin & Rubin, 1995, p. 161) that helps keep the participant focused on the main topic or theme of the interview. Three guides were developed for this study: one for nurse participants (Appendix J), one for patient participants (Appendix K), and one for family member participants (Appendix L).

Developing an interview guide required me to think carefully about the main theme and develop questions that linked aspects of the topic together in a logical way that made sense to interviewees. I organized questions for the initial interview guide by themes such as: a) introduction of the topic; b) how the process of managing relationships occurs; c) how contextual and systemic features or structural conditions within the acute care hospital environment facilitate or create boundaries to managing relationships and; d) closure of the interview. I also structured questions so that only one idea was introduced at a time in order to avoid confusion on
the part of the interviewee (Morse & Field, 1995). Because participants need to understand the intention of the interview questions, I avoided medical terminology.

I developed each guide to include general questions relevant to main concepts associated with the substantive area of inquiry (e.g. decision-making, collaboration) to capture various aspects of the process under consideration, namely, how nurses, patients, and family members manage relationships during the provision of care in acute care hospital settings. For example, to nurse participants I asked:

Today we are talking about how nurses, patients, and family member(s) collaborate to plan and provide patient care in the acute care hospital setting. Perhaps you could start by describing a recent situation in which you collaborated with a patient and their family member(s) for the purpose of planning and providing patient care?

I used open-ended interview questions to encourage participants to express their feelings, opinions, and experiences. For example, in the initial interview guide for nurse participants under the general topic of ‘introduction of topic and understanding significance and meaning from the nurses’ perspective’, I asked: How did the collaborative process related to planning and providing patient care affect you as a nurse? I intended to determine if and how the concept of collaboration fit with the nurses’ perceptions of their interactions with patients and/or family members. When participants’ responses lacked detail, depth or clarity, I used general probes as prompts to encourage them to elaborate, as suggested by Rubin and Rubin (1995). For example, the guide included brief notes to remind me to probe specifically around the meaning and significance of interactive processes – collaborative or otherwise.

Although I prepared interview guides, I did not use them rigidly. I framed the interview using a particular topic but kept boundaries flexible so I could remain open to participants’ comments within the limits of the main theme. My questions evolved based on participants’ responses. In
the example that follows, I was trying to discover a nurse’s perspective about the importance of interactions between nurses and family members. I asked:

R: When nurses collaborate with family members, how do you think they (the family members) are affected?
N: Well, I think they feel part of the care; that they feel part of the healing process with the patient…which is good, I mean especially if they are going to be a care giver or help this patient when they go home, they need to know what they can and cannot do.
R: How do you think families are affected by the hospitalization of an ill family member?
N: I think it is very stressful for them. I think any patient coming into hospital give up so many rights. I mean, we take everything away; as much as you try not to but decisions are made; we’re giving you pills. I mean everything that you could do at home has all of a sudden been taken away from you so I think it [collaborating] gives something back to the family – some feeling of control. (N-01, 226-254).

At this point I followed the nurse’s lead and began the process of trying to tease out the concepts of nurses’ power and control over patients and family members and how that affected managing relationships. Power was a notion that I had not previously anticipated. My ability to remain open to the data, in this case the need to follow up on concepts of power and control, was critical to ensuring the relevance of the data to emerging theory as opposed to forcing it into what Glaser and Strauss (1967) referred to as “irrelevant directions and harmful pitfalls” (p. 48).

How the researcher conducts the interview is also an important consideration that can contribute to its success in terms of the detail and depth of participants’ descriptions (Morse & Field, 1995). I used introductions, thanked participants for their involvement, focused on participants during interviews, asked one question at a time, refrained from interrupting, and conducted interviews at a pace that seemed comfortable to participants. This demonstrated respect as indicated by Morse and Field. Respecting and accommodating moments of silence were also important. Moments of silence may be indicative of new realizations, insights, or may signal that the participant simply requires a few moments to pull their thoughts together (Morse
Richer descriptions result if participants are allowed to continue when they are ready as opposed to being rushed or cut off by a new question (Kvale, 1996; Morse & Field).

4.5.6 Audio-taping.

Because accurately capturing the conversation between the researcher and the participant is critical in grounded theory studies, I audio-taped and transcribed the interviews verbatim as soon after the interview as possible. Audio-taping is important because relying on memory is difficult (Silverman, 2000) and it facilitates listening and focusing carefully on questions asked and participants’ responses (Morse & Field, 1995). It also “preserves all of the words spoken in the sequence in which they were spoken” (Sandelowski, 1995, p. 373). Transcribing audio-tapes to text provided me with the opportunity to become intimately familiar with the data as indicated by Morse and Field. It also transformed the data into a format that was readily available for further analysis (Sandelowski). Transcribing my own interviews facilitated my abilities to critically examine and evaluate my interview techniques and adjust my approach as required.

Both ethical and practical implications must be considered when a researcher plans to audiotape an interview. In compliance with ethical requirements, I informed participants verbally and in writing that the interview would be audio-taped for analysis purposes. I also informed participants that they may request that the tape be turned off at any time. Conveying this information to each participant was necessary to ensure that informed consent was obtained.

Pragmatic concerns related to taping included ensuring that the equipment was functioning prior to the interview, carrying fresh batteries and extra tapes, operating the equipment properly, placing the recorder in a strategic position to facilitate the quality of the recording, and most importantly, remembering to turn the recorder on (Baxter & Chua, 1998; Easton, McCorish & Greenburg, 2000; Rubin & Rubin, 1995). Throughout data collection, it was often a challenge for
me to find an appropriate surface on which to place the recorder to facilitate the quality of the recording, especially in patient rooms. On one occasion the tape speed was set incorrectly resulting in the need for a second tape. Fortunately, the quality of the recording was not compromised. On another occasion the recorder was set on voice activation mode. This was problematic in that the recorder failed to activate quickly enough to voices so that parts of sentences were not recorded. I transcribed the audio-taped interview immediately to take advantage of my recall to fill in the missing sections of the conversation.

4.5.7 Participant observation.

Interpretive research methods that are guided by symbolic interactionism also focus on the interaction between the actors and other actors. According to Mead (1962), understanding of human beings is inferred from what they do, as well as what they think. To fully comprehend the human situation, therefore, researchers need to observe, partake, and interview (Charon, 1995). The primary purpose of participant observation is to get close to the activities and everyday experiences of people in their natural environments (Emerson, Fretz, & Shaw, 1995). Participant observation fits with the grounded theory method guided by Symbolic Interactionism; however, observation as a data collection method is somewhat controversial in terms of the role of the researcher. The primary concern associated with participant observation is the degree to which the behavior or actions of the participants are modified secondary to their awareness of being observed (Mays & Pope, 1995; Talbot, 1995). This is known as the Hawthorne Effect. Emerson, Fretz, and Shaw referred to this phenomenon as “consequential presence” meaning that the researcher’s presence may cause participants to react in a way that affects their behavior (p.3).

In an effort to minimize the effect of my presence, I implemented an observation strategy in which participants were fully aware that they were being studied. This approach is referred to as
‘overt’ observation; in overt observation, the level of participation by the researcher may vary from one of participant-as-observer whereby the researcher assumes a dual role of worker/observer, to observer-participant involving minimal participation, to one of complete observer (Emerson, Fretz, & Shaw, 1995). As a complete observer, the researcher assumes a passive, objective stance in their observation of others. Emerson, Fretz, and Shaw argued that it is not possible for the researcher to be completely neutral, detached, and independent of the observed phenomena. This position is consistent with symbolic interactionism, which suggests that the presence of the researcher influences both the context and the meaning of the action and interactions of those observed (Crooks, 2001). In spite of this obvious disadvantage, May and Pope (1995) argued that overt observation provides an important advantage over interview alone in terms of “circumvent [ing] the biases inherent in the accounts people give of their actions caused by factors such as the wish to present themselves in a good light, differences in recall, selectivity, and the influences of the roles they occupy” (p.183).

I assumed an active participant role. As an active participant, I remained visible to the participants but refrained from participating in any physical contact or interactive activities such as interviewing, interjecting, or seeking clarification during the observational experience. Symbolic interactionism supports my assumption that my presence affected the behavior of those being observed. In this sense, I was an active participant. Following any observational experience, I tried to interview participants to understand how they perceived my presence and how this influenced their actions or their perceptions of the actions of others. Post-observation interviews were not always possible. For example, often when day-to-day interactions or other activities occurred while I was on the nursing unit, participants in observed interactions or activities were not interested or were too busy to be interviewed.
While observation in the field allows the researcher to collect data related to human activity and the environment that interview data alone do not provide (Morse & Field, 1996), I had to consider informed consent. The main concern related to observation is to ensure subjects are protected from harm. Therefore, prior approval of an observational guide was obtained as part of the ethical review process. The observation guide (Appendix M) identified with as much predictability as possible who and what I intended to observe. My observations were focused on verbal and non-verbal communication between participants, physical characteristics of the participants, and the nature of the environment. The guide was not static; it became more refined as dictated by developing theory.

Numerous participant observational experiences were planned and/or arose spontaneously while in the field. Since the majority of participant interviews were conducted in the acute care hospital setting, many interactive episodes between various nurses (and other health care professionals), patients, and/or family members occurred in my presence. Such interactions provided important opportunities to explore participants’ perspectives about the nature and frequency of such interactions, how interactions may have been affected by the presence of the researcher, as well as the meaning and significance of such interactions. For example, during an interview with a family member participant (F-009) that occurred at the bedside, the nurse poked her head through the curtain drawn around the bed and began an interaction with the family member related to the care and progress of her mother (the patient). On the basis of this observation the following participant observation note was written:

Prior to turning the recorder back on, I asked the family member: From your perception, how meaningful is the exchange between yourself and the nurse that just occurred? She responded by saying that it was very important to her that the nurses’ initiate interactions with family members and that they do that by “checking on them just like L (nurse) did. She went on to say that “L” does that all the time but not all of the nurses did. Furthermore, she indicated that “working closely with the girls [the nurses] is great because then you
have a contact person if you need something. From this interaction on reflection, it was obvious to me that there was a level of familiarity between the nurse and the family member that allowed them to converse on an equal level with regard to the care of the patient. This observation was consistent with what the family member had described in terms of how important it was to the nurses that she has been there so much to help with the care of the patient and to act as a source of information. There was a degree of trust between them that was palpable in the exchange of information and the sense of agreement between them that everything was okay for the moment. It was interesting that once again the nurse did not acknowledge my presence at least not until the family member drew the nurse’s attention to what we were doing. Because I had nothing really to do with the patient, my presence and purpose of being there seemed to me to be inconsequential from the nurse’s perspectives (Participant observation note dated May 31, 2005).

Several hours were also spent prior to, between, and after interviews simply observing the environment on the various acute care units in the participating hospitals. This provided me with opportunities to make general observations related to nurses’ work, the systemic nature and physical characteristics of the work environment, as well as interactions between and among nurses, nurses and other members of the health care team, for example, physicians, pharmacists, unit clerks, and finally between nurses, patients and family members. In total, thirty-three hours of participant observation were completed.

4.5.8 Field notes.

Since it is difficult for any researcher to remember all the details of an observational experience, field notes are an important vehicle for recounting the experience during, and more importantly, immediately following the observation (Emerson, Fretz, & Shaw, 1995). Field notes include ‘jottings of salient points’ or details about the environment such as sights, smells, and sounds as well as physical and behavioral characteristics of people in the setting (Morse & Field, 1995). During my observations I made notes that were reworked in detail later. I used these notes to supplement my observational experiences (Emerson, Fretz, & Shaw).

I also included key events or things that stood out and my emotional, cognitive, or other personal responses to these incidents. I avoided judging the events or incidents and particularly
the observed behavior of others. Emerson, Fretz, and Shaw (1995) argued that "Prejudging incidents in outsiders' terms makes it difficult to cultivate empathetic understanding and to discover what importance local people give to them" (p. 27). I was open to the fact that people may respond to like or similar events in contrasting ways and tried to understand why they acted in a particular way. For this reason, following Emerson, Fretz, and Shaw's recommendations, I tried to talk to the participants about their impressions.

As with the act of observing others, writing notes during participant observation also requires informed consent from the participants. Furthermore, sensitivity is required in relation to when, how, and what the researcher writes in the presence of participants (Morse & Field, 1995). Participants may feel uncomfortable with or distracted by what the researcher is writing about them. Researchers should remain responsive to the feelings of others and avoid making notes about matters that may be embarrassing or confidential in nature (Emerson, Fretz, & Shaw, 1995). In an effort to capture detailed description of the interactive processes, it is important that field notes be written as soon as possible following the observational experience (Emerson, Fretz & Shaw; Morse & Field).

During the course of data collection, I informed participants prior to the start of each interview that brief notes might be taken in an effort to capture main themes of the conversation and/or ideas about subject areas requiring clarification or elaboration. Despite the need to do this, I made every effort to focus primarily on the participant and what they were saying. Following each interview and observational experience, field notes were written as soon as possible (Appendix N- Sample field notes). Although it was difficult, I wanted to capture as much objective observational detail about the subjects and the environment as possible. I offer this excerpt from the field notes written following patient interview 05 as an example:
We introduced ourselves to each other and both sat in chairs on opposite sides of a small desk in the Patient Care Coordinator’s office. The office was small and had no windows. The participant positioned a portable oxygen tank beside her and adjusted the oxygen tubing and nasal prongs that she was wearing. Her breathing was labored; she exhaled noisily through pursed lips. She was pale and slightly hunched over. Her attire was casual ‘street clothes’ – sweat shirt and bottoms. Before leaving us, the PCC told the patient to let her know if she needed anything and reassured her that I wouldn’t make her nervous. Earlier I had been told by the PCC that the patient’s breathing tends to become more labored with increased anxiety. The patient stated that she “would be fine”. The door was closed so we had complete privacy and there were no interruptions at any time during the interview.

Throughout the interview I found her [the patient] to be very articulate, despite her labored breathing. She explained to me that she was doing “controlled breathing” – slow, steady breaths in through her nose and out through her mouth. She took her time answering questions (due to the difficulty she experienced breathing and talking at the same time) but she had a good level of understanding; took time to critically reflect on the questions before answering, and did not hesitate to ask for clarification if she did not understand a question posed to her (P-05, September 9, 2004, p. 1).

While maintaining objectivity is important when writing field notes, it is equally important to keep track of subjective biases, hunches, and hypotheses in relation to the setting or phenomenon in a personal journal or diary (Morse & Field, 1995). Richardson (2000) referred to this form of field note as ‘personal notes’ (p. 941). Richardson argued that it is important to record feelings and impressions because they affect what and how we claim to know.

4.5.9 Personal journal.

Throughout the process of data collection, I became aware of subjective, personal biases or unsubstantiated hunches related to the substantive area, setting, and phenomena. Although my hunches may have later proved erroneous, Morse and Field (1995) maintained that it is important to keep track of subjective impressions. Hall and Callery (2001) argued that it is important that the researcher make transparent the influences of investigator-participant interactions (reflexivity) and power and trust relationships (relationality) during the research process in order to enhance the validity of the findings. Journaling provides a vehicle by which the researcher can
explore and explain his/her own perceptions and constructions of the phenomenon and acknowledge how these affected the inquiry (Chiovitti & Piran, 2003).

Throughout the study, I recorded my personal reflections on interview or observational data. My writing generally included reflections on the effect that I may have had on the participant(s) or on our overall interactive processes, specifically with regard to issues of power and trust. For example, in addition to a field note written following nurse participant interview 03, I made a separate journal entry to record my thoughts about how my possibly overly enthusiastic verbal and non-verbal responses to the nurse’s perspective on family may have influenced how she answered my questions. The following is an excerpt from my journal entry dated August 04, 2004:

I was feeling very much at ease with the nurse and she appeared relaxed with me and with the interview process. I found myself especially keen to hear her thoughts about how the family theory that she had been taught didn’t quite fit in with practice in the ICU and probably probed a little too much around this topic. I know that I showed approval for her comments and prompted her to continue and to elaborate during this part of the interview. It was likely that she was encouraged to continue based on my positive response but is it possible that I was overly encouraging? I will have to be aware of my verbal and non-verbal responses to comments made by participants. Giving off messages of approval or disapproval may potentially influence their perspective more so than is desirable to maintain openness to participant’s views.

Reflecting on this entry provided an opportunity to think carefully about how my responses could influence participants and the data. I realized that messages of approval or disapproval were forms of power that could influence how participants responded to my questions.

The insight gained through journaling prompted me to take greater care to be aware of my verbal and particularly my non-verbal responses during interviews.

4.6 Data Analysis

From the beginning of data collection, I engaged in constant comparative analysis or
generating theory from the raw data. Glaser and Strauss (1967) described the constant comparative method as “generating and plausibly suggesting…many categories, properties, and hypotheses about general problems” (p. 104). The constant comparative method, which involves comparing and contrasting data by incident, clustering codes to develop categories, integrating categories and their properties, delimiting the theory, and finally, writing the theory, required me to use a balance of inductive and deductive logic. Inductive logic was reflected in the ongoing construction of theory from data; direction for further data collection was an outcome of deductive analysis of codes induced from data. One outcome of concurrent data collection and analysis, therefore, was my increased sensitivity and wisdom about my data in terms of “where to take it conceptually and where to collect more data” (Glaser, 1978, p. 6).

Central to the process of data analysis in grounded theory is the conceptual code. Coding provides the basis for interacting with and naming and categorizing data, and occurs on a continual basis as data are collected and studied (Charmaz, 2000). As Glaser maintained, coding ones data allows the investigator to move to a theoretical level of analysis by fracturing data and grouping them into codes that conceptualize underlying patterns within the data (Glaser, 1978). By developing relationships between conceptual codes, one develops grounded theory (Glaser).

Two general types of codes are generated: substantive codes and theoretical codes (Glaser, 1978). I used substantive codes to conceptualize the “empirical substance of the area of research”, whereas I used theoretical codes to “conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into the theory” (Glaser, p. 55). I began coding with open coding followed by selective coding for a core variable or variables.
4.6.1 Open coding.

Open coding was described by Glaser (1978) as "coding the data in every way possible" (p. 56). Open coding procedures involve the initial development, comparison, and contrast of incidents within the data to identify as many categories as possible (Dey, 1999; Glaser 1978; 1992). As coding progresses, new categories are constructed and new incidents are identified that fit under existing categories. Glaser (1978) maintained that the process of open coding allowed the analyst to "see the direction in which to take his [her] study by theoretical sampling before he [she] becomes selective or focused on a particular problem" (p. 56).

To ensure that open coding procedures are used properly, Glaser (1978) offered a set of general rules to govern the process. The first rule was that the researcher must constantly ask three questions of the data: "What is the data a study of"? "What category does the incident indicate"? What is actually happening in the data or what is the basic social- psychological problem that the participants face? Continually asking these questions enables researchers to be sensitive to new issues and focus on patterns among incidents that give rise to codes (Crooks, 2001; Glaser).

The second rule is that open coding requires line-by-line analysis. The third rule is that the analyst must do his/her own coding. While conducting line by line analysis, I assigned codes or descriptive labels to phrases, sentences, or groups of sentences within the data. Initially, I labeled incidents on the basis of "in vivo" codes, meaning in "the language of the substantive data itself" (Glaser, 1992, p. 45) and expressed them as gerunds. Gerunds or action words are used as much as possible to preserve the emic perspective (Morse & Field, 1995). For example, open (in vivo) codes identified in the first interview conducted for this study (P-01) included: feeling vulnerable, complying, feeling reassured, just floating, [nurses] just doing their job, telling,
checking on, assuming. For Glaser (1978), line by line coding of all data was important in that it “forces the analyst to verify and saturate categories, minimizes missing an important category, produces a dense rich theory, and gives a feeling that nothing has been left out” (p. 58). I found that coding the data myself was not only efficient but also enhanced my theoretical sensitivity which is important to achieving conceptual saturation, as suggested by Glaser.

As more data were collected, I created new categories and new incidents fit existing categories until patterns began to repeat. For example, while conducting line by line coding in the context of Glaser’s three questions for the first interview conducted (P-01) the following ten codes were generated: getting to know, asking questions, busyness/time, expectations, information sharing leads to trust, impact of social forces, going along with it, power and control of information, what nurses do, and personality factors. For subsequent data, I not only engaged in line by line coding, but also comparison of codes. By the fourth interview (P-03), additional codes such as ‘intelligent selection’ which seemed to describe a process of relationship management that was nurse driven, and ‘patient vulnerability’ or the need to feel secure were created. By the eighth interview the notion of the squeaky wheel had been identified by several participants.

As data collection and analysis progressed, I saw incidents in the data that seemed to be related. For example, codes such as information sharing, developing trust, and patient vulnerability seemed to emerge as a significant component of a higher level category referred to as ‘building rapport’. Following interviews N-03, N-04, and N-05 I identified the concept of ‘stepping back’ or moving to a lower level of engaging. I also identified a clearer pattern of interaction among nurses, patients, and family members that not only included various
progressive stages of development, but also conditions and barriers that constrained or facilitated the process.

Although it was ultimately my interpretation of the data that shaped the emerging codes and categories, Glaser’s (1992) third rule, which relates to theoretical sensitivity and is consistent with symbolic interactionism, is that I must remain open to the data and avoid a priori hypotheses. In other words, I must seek meaning and understanding from the actors’ perspectives as to the factors that influence how they behave in a given situation, and what meaning they attach to their actions. In Glaser’s view, remaining open to the data means that the “analyst starts with conceptual nothing – no concepts” (p. 39). As I engaged in the coding process, I experienced insights, feeling, thoughts, and later ideas about emerging relationships and captured them in memos.

Glaser’s fourth rule, which is critical to the process of generating grounded theory, is to always interrupt coding to memo ideas. Glaser (1978) wrote: “memos are the theorizing write-up of ideas about codes and their relationships as they strike the analyst while coding” (p. 83). Memoing is a constant process that serves several important functions in generating theory (Glaser). For example, memo writing helps track and preserve ideas; promotes insight into tacit assumptions; increases the conceptual level by identifying themes and patterns in data; captures speculations about the properties of the categories, relationships between categories, or possible criteria for selection of additional participants; and facilitates the integration of categories to generate theory (Glaser; Morse & Field, 1995).

To illustrate the importance of memos to the process of generating theory that is grounded in the data, I refer to a series of memos I wrote related to the notion of collaboration — a concept I thought to be relevant in the early stages of data collection.
March 2005: In acute care hospital settings, nurses do not necessarily collaborate with all patients and/or family members...The primary reason cited for this is because nurses either ‘do not have time’ or do not perceive that there is a need. Instead, collaborative episodes seem to occur primarily on an ‘as needed basis’.

April 2005: It is becoming more and more evident that collaborative processes between nurses, patients and family members occur on a selective basis. That is to say that nurses appear to collaborate with patients and/or family members in different ways, for different reasons, and for varying amounts of time...

July 2005: In acute care hospital settings, nurses do not necessarily collaborate with all patients and/or their families – this has been consistently acknowledged by all nurse, patient, and family member participants. In fact, the data suggest that there are instances when nurses, patients, and especially family members do not interact at all – at least not in a therapeutic way.

December 2005: ...various levels of interaction between nurses, patients and/or family members can be identified within the context of the acute care hospital environment. The initial level of nurse, patient and/or family member interaction achieved is dependent on the extent to which various systemic and contextual conditions align to create an environment conducive to interaction. The more mutually favorable terms or conditions are perceived to be, the more quickly nurses, patients and/or family members move towards achieving personal engagement...There can also be a decline in the level of engagement.

As demonstrated by these memos, although I initially thought collaboration might be a theoretically significant category to explain how nurses, patients, and family members interacted, with further sampling and analysis, it became evident that collaboration did not capture the nature of interaction described by the participants. Instead, a category I referred to as engagement or engaging emerged. In response, I resumed collecting data through theoretical sampling and began delimiting the theory through selective coding to determine if progressive engagement ‘best fit’ the pattern of interaction reflected in the data (Glaser, 1978). This recursive process was consistent with the grounded theory method, where tentative theoretical explanations are generated and modified on the basis of incoming data that confirm or refute these explanations (Davis & Harris, 1989; Sandelowski, 1995). This process allows the analyst to become increasingly sensitized to categories that may provide an answer (Davis & Harris; Glaser; Sandelowski). Once the analyst begins to see the prospects for a theory, he/she begins selective coding (Glaser).
4.6.2 Selective coding for a core category.

Following my hypothesis that progressive engagement met the criteria for a core category, I undertook a recursive process of theoretical sampling, constant comparison of data sets and selective coding over several months. Selective coding refers to the process of categorizing, re-categorizing, and condensing all first level codes around a possible core category in an effort to determine if it accounts for most of the variation of the central phenomenon of concern and integrates all other categories (Glaser, 1978; Kendall, 1999). I used second level coding to contribute to raising the conceptual process to a higher level of abstraction to account for more variability in the data, as well as facilitate theoretical sampling to delimit the theory to one core variable as suggested by Glaser.

Upon commencing second level coding, I theoretically sampled around concepts that seemed related to progressively engaging. For example, I developed codes such as the squeaky wheel, taking time, stepping back, and feeling each other out and developed conditions that seemed to relate to hypothesized stages for engaging. When I had completed forty interviews, I found that my tentative core category - progressively engaging held a central position to other possible categories and through selective coding it became clear to me that this proposed core category was “processing out” (Glaser, 1978). In other words, for me it appeared increasingly evident that progressively engaging was not only a core category but also a process which accounted for two or possibly three stages of engagement. Each hypothesized stage seemed to account for various factors such as acuity (e.g. medical diagnosis, nursing diagnoses, communication of need), time (e.g. acuity, priority, work load, competing demands), personal factors (e.g. language barriers, personality, the ‘squeaky wheel’), and systemic factors (e.g. rules, routine, lack of privacy); getting to know; and/or building rapport. Through one-upping with my supervisor (Glaser,
1978) it became evident that there were conditions or terms of engagement that determined the stage of engagement attained in relationship as well as conditions in which nurses, patients and/or family members stepped back from engaging or failed to engage.

4.6.3 Core category.

Glaser (1978) maintains that the goal of grounded theory is to generate a theory that accounts for how participants process the primary concern or problem in the setting. The core category is central to constructing theory because it accounts for most of the variation in a pattern of behavior (Glaser); all other categories and their properties are related to it. Based on its ability to integrate categories, the core category leads to theoretical completeness but remains amenable to modification in response to changing conditions (Glaser). Identifying a core category takes time; however, it eventually stands out on the basis of its ease of saturation, relevance, and workability in relation to all other categories (Glaser). Additional criteria for determining the core category include: its frequent reoccurrence in the data; it’s clear and grabbing implication for formal theory; and the relevance and explanatory power it provides in the analysis of the processes under consideration (Glaser).

As my ongoing search for a core category unfolded, possible core categories such as selective collaboration that I believed offered an explanation of what was happening in the data ultimately failed to “carry through” (Glaser, 1978). In other words, the notion of selective collaboration could not fully account for the pattern of interaction that emerged as data collection and analysis progressed. Instead, a new tentative explanation in the form of a category referred to as progressively engaging was created. Progressively engaging referred to a continuum of interaction. My early conceptualization of this continuum included being less engaged (referred to as ‘just doing the job) at one end to being fully or more personally engaged (referred to as
'doing the job with heart') at the other. Moreover, the category of progressively engaging seemed to account for particular conditions that participants described that either facilitated (e.g. personality, increased acuity) or constrained (e.g. perceptions of time, language barriers) efforts to manage nurse-patient and/or family relationships in the acute care hospital settings by engaging. In other words, there seemed to be conditions that influenced nurses’, patients’ and family members’ willingness to engage with each other at various stages on the continuum. Early conceptualization of the core category of progressively engaging was captured in the memo excerpt that follows:

The continuum of interaction that reflects the level of nurse, patient and/or family interaction in acute care settings at any given time (at least those included in this study), appears to be characterized by obligatory levels of interaction at one end of the continuum through to progressively higher levels of engagement to possibly achievement of personal engagement at the other end. Interaction characterized as being obligatory in nature is associated with what nurse, patient and family member participants consistently describe as ‘just doing the job’. Nurse, patient and family member participant descriptions of nursing care delivered at the level of ‘just doing the job’ is focusing on the elements of nursing work without engaging with others on a personal level (December, 2005).

At this earlier stage of theory construction, I believed the core category represented a basic social psychological process, because it captured other categories that were suggestive of progressive stages of engagement. The categories that related to the core were establishing competence, professional engagement, and personal engagement. On the basis of considerably more analysis via concurrent processes of coding, one-upping with my supervisor, theoretical and process memoing, and constant comparison, a substantive theory was drafted – although several revisions to the theory were undertaken (Appendix P). As ongoing analysis enhanced my levels of conceptual abstraction and I accounted for more variation in the data, I next determined how the core category and the substantive codes were theoretically related.
4.6.4 Theoretical coding and sorting.

In an effort to confirm my hypothesis that progressively engaging was a basic social psychological process that explained how nurses, patients, and family members managed their relationships in acute care hospital settings, I conducted theoretical coding. When theoretically coding, analysts systematically relate categories in theory by “recognizing what is important in the data and giving it meaning” (Morse & Field, 1995, p. 161). According to Glaser (1978), “theoretical codes conceptualize how the substantive codes may relate to each other as hypotheses to be integrated into a theory” (p. 72). Theoretical coding promotes further conceptual abstraction and generates new ideas that give the theory integrative scope, breadth and perspective (Glaser).

To enhance the process of theoretical coding I constructed a theoretical diagram (Glaser, 1978). Developing a diagram is a way to theoretically code pictorially, which facilitates writing up hypotheses about the substantive meaning of the connections depicted (Glaser). The diagram was useful as a basis for discussion between me and my supervisor – discussions which facilitated the achievement of continually more advanced conceptualizations of the theory. Among these advanced conceptualizations was my construction of the theoretical code ‘terms of engagement’. Initially terms of engagement accounted for those conditions that facilitated a willingness to engage at the first stage (focusing on tasks) but with further analysis the terms of engagement came into play at each stage of the process. I undertook several revisions to my diagram to reflect these theoretical advances.

I undertook theoretical or conceptual sorting concurrently with theoretical coding; the diagram was extremely useful for the sorting process. Theoretical sorting refers to “putting the fractured data back together” but on a conceptual, creative level (Glaser, 1978). It is a very
important step preceding the writing of the theory because it forces connections between categories and properties, generates dense, complex theory by stimulating more memos, and eventually integrates relevant literature into the theory (Glaser).

The process of theoretical sorting (and coding) was facilitated by my theoretical sensitivity. Glaser (1992) described theoretical sensitivity as being dependent on the researcher’s knowledge, understanding, and skill, and which in turn “foster[s] his [her] generation of categories and properties and increases his [her] ability to relate them through hypotheses, and further integrate the hypotheses, according to emergent theoretical codes” (p. 27). I used my knowledge about family nursing, skill at data analysis, and intense interaction with the data to develop concepts and relate them to one another. Simultaneously, I tried to treat any predetermined ideas as simply another source of data.

The core category ‘progressively engaging’ related easily and meaningfully with the other categories constructed, namely: focusing on tasks, feeling each other out, building rapport, stepping back, opting out and falling through the cracks. While core categories can take many forms (e.g. a process, a condition, a consequence), if it is a process it must have at least “two or more clear emergent stages” that reflect a process by which participants manage the problem under investigation and is hence referred to as a Basic Social Psychological Process (BSPP), (Glaser, 1978). Glaser (1992) defined basic social processes as “fundamental patterned processes in the organization of social behaviors which occur over time and go on irrespective of the conditional variation of place” (p.100).

4.6.3 Saturation and completeness.

When second level coding of all sources of data (memos, field notes, transcripts) no longer yields new information, that is, new data fit into existing categories (Charmaz, 2000), and the
core category accounts for most of the variation in behaviors, saturation is reached (Morse & Field, 1995). In the context of saturation, Glaser (1978) referred to cutting off rules which include running out of memos, as well as theoretical and scholarly completeness. Theoretical completeness means that the analyst has explained the phenomenon under investigation with as few concepts as possible and with as much scope and variation as possible (Glaser). Based on the analyst’s knowledge of the literature, scholarly completeness refers to the point in which the analyst feels that his/her theory makes a “integrative and recognizable” contribution to the relevant literature (Glaser, p. 126).

Saturation and the subsequent cutting off of theory construction is, therefore, a subjective judgment – a conscious decision by the analyst based on the belief that he/she can’t get any more from his/her ‘conceptual work (Glaser, 1978). After analyzing forty participant interviews, the patterns of behavior that emerged were accounted for in categories I constructed which captured the stages of progressively engaging. For example, focusing on tasks (the first stage of progressively engaging) accounted for when nurses and patients and/or family members came together – that period of time when there was limited familiarity with each other and the primary focus of interaction was on the delivery of priority physical/medically delegated care.

Given the constraints of dissertation research, such as time and resources, I, in consultation with my research supervisor, concluded that my conceptualization of progressively engaging, including the three stages of engaging, met the criteria for saturation as described above. It explained how nurses, patients, and family members managed their relationships within the acute care hospital settings and accounted for the conditions or factors that participants described that facilitated or constrained their relationships with one another. Moreover, I found that progressively engaging made a significant contribution to the substantive literature by offering
an explanation of nurse, patient, family interaction that is grounded in practice – that is, it is based on the perspective of participants actively engaged in the social psychological process of managing their relationships in these settings. One of the most significant tests of saturation however, is that the conceptual work meets the requirements for rigor – that is, the theory constructed sufficiently explains with “concepts that fit, work, have relevance and are saturated” (Glaser, 1978, p. 125).

4.7 Criteria for Rigor

Theory, according to Glaser and Strauss (1967), is a strategy for handling data by providing a conceptual framework for describing and explaining it. Theory must be readily understandable, relevant, have practical application to the situation under study, and “provide clear enough categories and hypotheses so that crucial ones can be verified in present and future research…” (Glaser & Strauss, p. 3). Glaser and Strauss maintained that the best approach to generating valid social theory is through systematically developing theory from data. Indeed, when I used the grounded theory process with its guidelines and detailed strategies for collecting, coding, analyzing, and presenting data, it went hand in hand with verifying it [emerging theory] (Glaser & Strauss, p. 3). It is on the basis of how the theory was generated, as well as how much ‘grab’ it has, that the validity of grounded theory ought to be judged (Glaser, 1978; Glaser & Strauss; Lomborg & Kirkevold, 2003).

The term ‘grab’ is used by Glaser and Strauss (1967) and Glaser (1978; 1992) to describe grounded theory deemed to be well constructed, because people find it interesting, meaningful, and reflective of the essence of the phenomenon under investigation. In order to attain grab, however, the theory must meet certain criteria. These criteria include: fit, work, relevance and modifiability.
The notion of 'fit', initially described by Glaser and Strauss, means that the theory constructed from the data “fits the situation being researched” (1967, p. 3). In other words, the theory clearly corresponds with the social reality and is; therefore, readily understandable to those for whom it is relevant. In order to achieve fit, a theory must account for most of the variation in the data, codes, and categories. In other words, the most salient codes and categories account for the greatest amount of variation in the data. Categories must be “readily applicable to and indicated by the data under study” as opposed to forced into pre-conceived or pre-existing theoretical categories (Glaser & Strauss, p. 3).

According to Glaser (1978), an important property of the notion of ‘fit’ is emergent fit. Emergent fit involves concurrent refitting of extant categories with emerging data to ensure that the category still ‘works’, thereby earning its way into the emerging theory. Allowing for changes from emerging data contributes to the modifiability of the theory.

I attended to the criteria of emergent fit throughout this study by employing the peer research support group strategy. This strategy enhances the quality of qualitative research by facilitating the process of review and commentary by support group members regarding such documents as interview transcripts and memos, and provides a forum to discuss the researcher’s ideas (Jacelon & O’Dell, 2005). Specifically, I sought feedback from my research supervisor. I did this by submitting written memos, copies of transcripts, proposed substantive theories, and draft descriptions of categories and the core variable at various stages of their development to my research supervisor for feedback about how well the emerging categories fit the data. I also met with my supervisor regularly throughout the study (and with the other members of my research committee later in the process), to discuss my data analysis work; obtain feedback and exchange ideas. In addition, I took advantage of opportunities to discuss my proposed substantive theory at
various stages of its evolution with colleagues and peers. For example, as a guest speaker in a graduate level qualitative research course I presented an early version of the core category, progressively engagement, and received feedback from graduate nursing students. Based on their knowledge of the substantive area and their clinical knowledge and practice, they indicated that the core category and stages resonated with their experiences and expressed enthusiasm for the ability of the theory to explain interpersonal dynamics associated with nurse, patient, and family relationships in acute care hospital settings.

As previously mentioned, grounded theory must also ‘work’. Glaser (1978) described the notion of work as: "a theory should be able to explain what happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry" (p. 4). In order for theory to ‘work’ Glaser emphasized the need to “get the facts” about what is “really going on” in the substantive area (p. 4). While obtaining the perspective of the actors is critical to this aim, the underlying assumption is that a natural world is available for observation and analysis (Hall & Callery, 2001, p. 260). This becomes problematic especially if one adopts an interpretive stance such as symbolic interactionism which assumes that meaning is created through interaction. Hall and Callery wrote:

Because data are produced through the criterion of meanings during processes of interaction, it follows that the quality of the data will be influenced by the nature of the relationship between the researcher and the participant, therefore, the nature of that relationship requires the attention of the grounded theory investigators (p. 260).

Hall and Callery further argued that grounded theory researchers must take measures to account for the effects of subjectivity on the research process in order to enhance the validity of the emerging theory. Such measures include the incorporation of reflexivity which “addresses the influence of the investigator-participant interactions on the research process”, and relationality which “address power and trust relationships between participants and researcher” (p. 258).
In this dissertation study, I dealt with reflexivity and relationality by utilizing personal journaling as a self-monitoring tool. Post-interview and observational journaling provided a vehicle for tracking and increasing my sensitivity to personal views and constructions and how these might influence the inquiry process (Chiovitti & Piran, 2003). For example, following my interview with a patient and her daughter the following entry was made in the researcher's journal:

While both mother (patient) and daughter describe a process whereby some nurses went more out of their way [e.g. showing interest and concern] than others, the patient’s view seemed to be tempered by her experience in hospital e.g. watching nurses cope with the many demands in their work” (June 30, 2004).

This insight contributed to the level of theoretical sensitivity in relation to patients' perceptions of contextual and systemic factors vis-à-vis their interactions with nurses as opposed to family members who may not have the same awareness of such factors.

In another example, I addressed relationality in the following journal entry dated June 30, 2004:

I found myself feeling frustrated with what I perceived to be the lack of honesty by this nurse in terms of how she portrayed her interactions with family. It just seemed so inconsistent with what I have heard from others and from what I have read that it just seemed to good to be true! I was kinda aware of my bias (or possible bias) but pressed on anyway trying to get at ‘what really happens’ as opposed to what the RN wanted me to think happens. Because the interview happened at the spur of the moment and because we didn’t really have any time to get comfortable with each other, I wonder if the nurse felt threatened by me and by my questions. She may have been skeptical about my intentions and maybe she thought I was ‘investigating’ how well the nurses on her unit did family nursing – or not. She may have felt on the defensive a bit.

This journal entry provided the opportunity to reflect on a possible power imbalance between myself and a participant. It became evident to me that not only could this imbalance affect the data collected, but it could also influence how I interpreted the data. This realization resulted in modifications in my approach, including making sure that there was sufficient
time to conduct interviews without being rushed and incorporating more opportunity for participants to ask me questions about myself and/or the research I was conducting. It also was an opportunity to reflect on the importance of journaling about my impressions in order to increase my awareness of how they influenced data interpretation.

Returning to Glaser and Strauss’ (1967) criteria of rigor, when grounded theory fits and works, relevance is attained. Relevance means that the core basic social problems and the basic social processes that have emerged are recognizable, comprehensible, and plausible to others including the participants and are parsimonious, yet broad in scope (Crooks, 2001; Glaser, 1992; Morse & Field, 1995). Parsimony and scope refer to the ability of the theory to account for as much variation in behavior within a substantive area as possible. Breadth of the theory refers to its ability to be ‘sufficiently general’ meaning that it is “applicable to a multitude of diverse daily situations as they change through time” (Glaser & Strauss, p. 237).

I was able to account for the criteria for relevance in my developing theory by employing a form of member checking (Sandelowski, 1993). Member checking involves a process of seeking feedback from study participants about how they perceived the relevance and meaning of the researcher’s development of categories that seemed to capture participants’ descriptions of their experience related to nurse, patient, and family member interactions. For example, in an effort to understand and verify the relevance of how the social structural condition of asking questions related to the category of nurse busyness, and influenced nurse, patient, family member interactions, I asked nurse participant 16 the following question:

  Researcher: I just want to ask you about questions. I am hearing a lot about this notion of questions and because nurses are so busy um, that a lot of times there is an expectation by nurses that if people need something or you, a patient or a family member, they will ask. Does that resonate with you or no?
  Nurse: Not always. Some of them say, you know, well I didn’t ask because I see that you are so busy that I hate to ask. (May 4, 2005, N-16, 347-357).
In another example, I sought to determine the relevance and meaning of the emerging category of nurse busyness from the perspective of a family member participant when I asked:

I have talked to a lot of nurses, and patients, and family members like yourself about this process [of nurse, patient, family interaction] and there are some things that consistently come up and I’ll throw them at you and see what you think. One of the things that comes up a lot is time – that nurses are so busy that they, it is very difficult for them to interact with families, to work with them and include them in care. Is that... do you see that? Do you see that nurses are too busy? Or is that not a factor? Family member: Uh, okay, I will see some nurses really busy. They doing every detail work and... But I cannot say all of them like that.... etc. (June 24, 2005, F-010, 235-261).

By checking the degree of recognizability, comprehensibility, and plausibility of emerging categories with participants - especially in the later stages of data collection I was able to confirm the relevance of key concepts and hypotheses about how concepts were related to one another with the participants. Also, notwithstanding time constraints and other limitations to the research study, I was also able to enhance the ability of the emergent theory to account for as much variation in behavior associated with the core category as possible.

Finally, grounded theory must be modifiable. Indeed, theory generation is considered an ongoing, modifiable process (Glaser, 1978). Modifiability incorporates the recognition that the process of theory development is tentative, dynamic, and requires the researcher to be open and inquisitive with regard to new data and insights. Although the basic social processes that emerge through grounded theory remain in general, “their variation and relevance is ever changing in our world” (Glaser, 1992, p. 5). Thus, as new data emerge, the theory must be modified to fit these variations. In this way, grounded theory maintains relevance and parsimony in terms of its explanatory powers. As circumstances change and new data surface, the theory should be amenable to modification in order to account for them.
Throughout the process of developing my theory of progressively engaging several modifications to the theory were necessary in response to the emergence of new data and insights. The concept of positive and negative interpersonal dynamics, for example, was initially conceptualized as factors affecting how nurses, patients, and family members first came together around care. With further analysis, however, I determined that interpersonal dynamics influence nurse-patient and/or family relationships at each stage of progressively engaging. Consequently the emerging theory was modified to fit this new insight thereby enhancing its relevance and workability via the data.

4.8 Limitations

Through use of the qualitative research process, the researcher strives to make sense of reality by examining phenomenon for patterns in meaning and to infer more abstract generalizations in the form of concepts and relationships between concepts – in other words the “construction” of theory (Morse & Field, 1995). Using the grounded theory method, the investigator employs a primarily inductive approach to data analysis of “everyday behaviors and organizational patterns to generate a theoretical explanation” about a specific social phenomenon (Hutchinson & Wilson, 1993). While the ultimate goal is to explain the social world through theory based on rich description of phenomenon, the level or degree of explanatory power varies depending on such factors as the nature of the research and the research question(s), sample size, length of time in the field, and so on (Hutchinson & Wilson).

Since the research questions proposed in this study focused on nursing concepts grounded in a particular nursing practice context, a limitation of the study is that the theory constructed is applicable only to similar groups (nurses, patients and family members) in similar contexts and, therefore, constitutes a mid-range theory (Morse & Field, 1995). The research findings are also
constrained by the small sample size secondary to the nature of the busy acute care hospital setting and the degree of willingness and/or availability of nurses, patients, and family members to participate. Moreover, sample size was further constrained by such issues as limited time in the field secondary to restricted access within the hospital and Ph.D. degree completion deadlines.

In addition to sample size and time limitations, the research findings reported are also constrained by age, gender, and, to a certain extent, cultural representation. The majority of patient and family member participants were Canadian, Caucasian females over the age of fifty years. Nurse participants were Canadian female registered nurses working in acute care hospital settings. Thus the theory is relevant to Canadian registered nurses working in acute care hospital settings and mid-life or elderly patients and families, but may not be applicable in other countries, to health care settings in or outside of Canada, or for younger patient and/or family populations.

Because my sample is part of a larger population, some applicability may be construed (Dempsey & Dempsey, 2000). Morse (1999) argued that, although sample sizes in qualitative research tend to be smaller, the theory tends to be comprehensive, complete, saturated, and accounts for negative cases because the participants are purposefully and selectively chosen based on the anticipated contribution they can make toward the emerging theory. This means that the theory may be applicable in similar situations in terms of the nature of participants and their hospital settings.

4.9 Summary

I used the grounded theory method guided by symbolic interactionism as my strategy of inquiry in this study. From the symbolic interactionist perspective, the aim of grounded theory is
to understand and conceptualize complex interactional processes and construct theoretical explanations for the phenomenon under investigation. In the case of my study, the phenomenon under investigation was the perceptions and behaviors of nurses, patients, and family members as they managed relationships during care giving in acute care hospital settings.

In this chapter, I have provided an overview of the grounded theory method and described the research design including sampling criteria and specific data collection and analysis processes. I elucidated ethical considerations and my approaches to them. I have described the construction of my core category, which is the basic social psychological process of progressively engaging. I also presented ethical considerations and issues of rigor. I have outlined criteria for rigor in grounded theory and how I attended to rigor. Progressively engaging with its three stages (focusing on tasks, getting acquainted and establishing rapport) is a core category that explains how nurses, patients and family members manage relationships in acute care hospital settings. I will present my findings in the chapter that follows.
CHAPTER FIVE

5 Research Findings

The purpose of this chapter is to present the findings of this research study. Specifically, I will describe the substantive theory of progressively engaging that captures how nurses, patients and family members manage their relationships during acute care hospitalization. To begin, I describe the participant sample, including demographic characteristics for the nurse, patient, and family member participant groups. Next I will present an overview of the theory. A more detailed discussion about the core variable – progressively engaging, and its major subcategories and indicators will follow.

5.1 Sample

Between May 07, 2004 and June 24, 2005 a total of forty participants were recruited. Seventeen interviews were conducted with nurses, ten with family members, and thirteen with patients. Participants were recruited from a total of ten acute care nursing units across four community hospitals in the Fraser Health Authority of British Columbia. The type of nursing units included four medical units, three surgical units, two transitory care or activation units, and one community hospital intensive care unit.

5.1.1 Description of patient participants.

In total, thirteen patients consented to participate in the study. As depicted in Table 1.1 – Demographic Characteristics of Patient Participants, the majority of patients, (9/13) were female. With the exception of one patient who was between thirty and thirty-nine years of age, all patients were over fifty years of age. One participant was employed; one was semi-retired; and eleven of the thirteen patient participants indicated that they did not work or were retired. Ten patient participants were married at the time of the interview. All patient participants were
<table>
<thead>
<tr>
<th>Patient Participants</th>
<th>P-01</th>
<th>P-02</th>
<th>P-03</th>
<th>P-04</th>
<th>P-05</th>
<th>P-06</th>
<th>P-07</th>
<th>P-08</th>
<th>P-09</th>
<th>P-10</th>
<th>P-11</th>
<th>P-12</th>
<th>P-13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: Male/Female</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
</tr>
<tr>
<td>Age: 0-39 yrs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>&gt;50 yrs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Culture: Canadian</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>European</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Marital status:</td>
<td>Married</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Other</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td># of Children</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Education: K- gr. 8</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>HS diploma</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>College Grad.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Employed</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>1st Hosp?</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>LOHS - days</td>
<td>5</td>
<td>3</td>
<td>21</td>
<td>5</td>
<td>3</td>
<td>11</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>11</td>
<td>30</td>
<td>90</td>
</tr>
<tr>
<td>Diagnosis: Hyst</td>
<td>H</td>
<td>W</td>
<td>H</td>
<td>D</td>
<td>D</td>
<td>H</td>
<td>D</td>
<td>H</td>
<td>D</td>
<td>H</td>
<td>W</td>
<td>H</td>
<td>D</td>
</tr>
<tr>
<td>Knee sx</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CA</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Stroke</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>COPD</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Back pain</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Fall</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bowel sx</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hip</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>UTI</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Support Person</td>
<td>H</td>
<td>W</td>
<td>H</td>
<td>D</td>
<td>D</td>
<td>H</td>
<td>D</td>
<td>H</td>
<td>D</td>
<td>H</td>
<td>W</td>
<td>H</td>
<td>D</td>
</tr>
</tbody>
</table>

Legend:  
Hyst = hysterectomy,  CA = cancer,  Knee Sx = knee surgery,  COPD = chronic obstructive pulmonary disease  
UTI = urinary tract infection,  Bowel SX = bowel surgery,  H = husband,  D = daughter,  W = wife
parents with between one and five children; (mean = 2.5 children). Levels of education varied with five participants completing grade nine to twelve and five obtaining a high school diploma. One participant indicated that he did not attend high school while three reported having earned a college diploma. None of the participants had university degrees. The majority (10/13) of patient participants self-identified as Canadian; three identified themselves as European. Length of stay in hospital for the patients ranged from two to ninety days; the mean length of stay in days was fifteen, (although this number is skewed by one 90 day stay). The median length of stay was five days. For the majority of patients (9/13), this was their first hospitalization for the current illness episode. Considerable variation in admitting diagnoses were observed for the patient participants interviewed. Illness episodes included: hysterectomy (surgery), knee replacement surgery, bowel surgery, two cases of fractured hip, acute back pain, multiple injuries sustained in a fall, cardiovascular accident (stroke), trans-ischemic accidents (TIA’s), an acute exacerbation of chronic obstructive pulmonary disease (COPD), cancer of the liver - newly diagnosed, and metastatic bone cancer – newly diagnosed, acute urinary tract infection (UTI). When asked to identify their main support person while in hospital the majority of patients (8/13) identified their spouses; four identified their daughters; and one patient identified a friend.

5.1.2 Description of nurse participants.

In total, seventeen nurses consented to participate in the study. As depicted in Table 1.2 – Demographic Characteristics of Nurse Participants, one hundred percent of the nurse participants were female and held a license to practice with the College of Registered Nurses of British Columbia. Fifteen of the nurses referred to themselves as a ‘staff nurse’, while two identified themselves as patient care coordinators. Fifteen of the seventeen nurses held a diploma
<table>
<thead>
<tr>
<th>Nurse Participants</th>
<th>N-01</th>
<th>N-02</th>
<th>N-03</th>
<th>N-04</th>
<th>N-05</th>
<th>N-06</th>
<th>N-07</th>
<th>N-08</th>
<th>N-09</th>
<th>N-10</th>
<th>N-11</th>
<th>N-12</th>
<th>N-13</th>
<th>N-14</th>
<th>N-15</th>
<th>N-16</th>
<th>N-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 yrs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49 yrs</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;50 yrs</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Culture:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Children</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Yrs of Practice:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-5 yrs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11-20 yrs</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21-30 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;30 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment status</td>
<td>FT</td>
<td>PT</td>
<td>PT</td>
<td>FT</td>
<td>FT</td>
<td>PT</td>
<td>PT</td>
<td>FT</td>
<td>FT</td>
<td>FT</td>
<td>PT</td>
<td>FT</td>
<td>FT</td>
<td>FT</td>
<td>FT</td>
<td>FT</td>
<td></td>
</tr>
<tr>
<td>Work hours/week</td>
<td>37.5</td>
<td>33</td>
<td>44</td>
<td>24+</td>
<td>37.5</td>
<td>24-26</td>
<td>33</td>
<td>44</td>
<td>44</td>
<td>37.5</td>
<td>37.5</td>
<td>35-40</td>
<td>24-36</td>
<td>48</td>
<td>30+</td>
<td>40</td>
<td>36</td>
</tr>
<tr>
<td>Nsg. Ed.:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>BSN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Legend:** SN = Staff Nurse, PCC = Patient Care Coordinator, FT = Full time, PT = Part time
in nursing education. Two nurses with diploma credentials also held a certificate in a nursing specialty or non-nursing related field. One degree nurse also reported having a certificate in a nursing specialty. A total of five nurses reported having post-secondary credentials in non-nursing fields of study. The majority of nurse participants (11/17) were employed on a full-time basis. The number of hours worked per week ranged from twenty-four hours to fifty-two hours with an average number of hours of 38.5. There was considerable variation among the nurses in terms of years of practice - between one and greater than thirty years. The majority of nurses (5/17) reported having between eleven and twenty years of experience. Three nurses reported having more than thirty years of experience. Most of the nurse participants (8/17) were over fifty years of age. The majority (10/17) of the nurses were married. The number of children among the nurse participants ranged from zero to seven (mean = 2.6). Most of the nurses (10/17) self-identified as Canadian.

5.1.3 Description of family member participants.

Family members were the most challenging group to recruit, because their visits were unpredictable and infrequent in nature, and many were unwilling to participate due to lack of time or other undisclosed reasons. Ten family members were interviewed in total, as depicted in Table 1.3 - Demographic Characteristics of Family Member Participants. One hundred percent (100%) of the family members were female and included four wives, five daughters, and one sister. Each family member participant either self-identified or was identified by the patient and/or nursing staff as the primary family care giver/support person to the patient while in hospital. The majority of family participants (8/10) were over the age of fifty years and self-identified as Canadian. Seven of the ten were married. All but one family member had children. The mean number of children among the remaining nine family members was two. There was a
range of between one and four children. In terms of education, two family members reported having attended grades nine to twelve; two graduated from high school; three completed some college courses; three completed a college diploma. None of the family had less than a grade nine education and none had participated in university education. Six of the family members reported that they were retired or did not work. Four family members indicated that they were employed; two were employed on a part-time basis. Only one of the family members indicated that she had missed time at work due to the hospitalization of her ill family member. The reasons for the ill family member’s hospitalization included: total knee replacement, cardiovascular accident (CVA), cancer, pneumonia, congestive heart failure, and fractured hip. The mean length of hospital stay among the ill family members of family participants was nine days with a range of three to twenty days. Although the demographic questionnaire did not include a question about how much time family members spent at the hospital, participants did provide this data.

Table 1.3. Demographic Characteristics of Family Member Participants

<table>
<thead>
<tr>
<th>Family Members</th>
<th>F-01</th>
<th>F-02</th>
<th>F-03</th>
<th>F-04</th>
<th>F-05</th>
<th>F-06</th>
<th>F-07</th>
<th>F-08</th>
<th>F-09</th>
<th>F-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29 yrs</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40-49 yrs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt; 50 yrs</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Culture:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canadian</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital Status:</td>
<td>Married</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Single</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Education:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS diploma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>College grad.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Semi-retired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part-time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sick leave</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retired</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship to Pt.</td>
<td>W</td>
<td>D</td>
<td>W</td>
<td>D</td>
<td>D</td>
<td>S</td>
<td>W</td>
<td>D</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>LOHS of pt. in days</td>
<td>3</td>
<td>5</td>
<td>11</td>
<td>20</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>16</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Pt. diagnosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee sx</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days missed work</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>0</td>
</tr>
</tbody>
</table>

Legend: Div. = divorced, D = daughter, W = wife, S = sister
Sx = surgery, # = fractured
while being interviewed. The amount of reported time spent at the bedside varied; however, nine of ten family member participants indicated that they visited their ill family member on a daily basis and many spent several hours each day at the hospital.

5.2 Progressively Engaging: Theoretical Overview

Progressively engaging is a basic social psychological process that accounts for how nurses, patients, and family members manage their relationships around care in acute care hospital settings. Progressively engaging describes how nurses, patients, and family members 'come together' in the course of patient care with varying levels of engagement. For example, some nurses, patients, and family members described their engagement as being more formal or business-like; others experienced a deeper, more personal engagement.

Levels of engagement were represented by three stages which included focusing on tasks, getting acquainted, and establishing rapport. The stages of engagement were affected by structural conditions and personal factors relevant to nurses, patients, and family members. Those conditions and factors facilitated or constrained efforts to manage their relationships by contributing to or detracting from shared meanings and perspectives. The level of engagement achieved in nurse-patient and family member relationships corresponded with feelings of satisfaction expressed by nurses, patients, and family members about their relationships and nursing care.

As nurses and patients and/or family member(s) came together to manage relationships, progressively engaging reflected their descriptions of both what they perceived to be less than ideal ways of managing their relationships, as well as what they perceived as ideal ways of managing their relationships. Their perceptions were based, in part, on the nature of the interpersonal dynamics they experienced in relationship. Interpersonal dynamics characterized as
Impersonal or business-like interactions could initiate the process of progressively engaging but also perpetuate a lower level of engagement. When nurses, patients, and family members experienced negative interactions they expressed dissatisfaction about the ways their relationships were being managed. Dissatisfaction was articulated as lack of trust and respect. For example, family members recounted feeling “invisible”; patients expressed feeling like “just another patient in the bed”; and nurses described feeling like “handmaidens”. The outcomes of lower levels of engagement were described as nurses “just doing the job”, wherein the focus of care was on routines and skill competencies, without a sense of connection.

If interpersonal dynamics were perceived positively and fit with what nurses, patients, and family members believed ought to happen in managing their relationships, higher levels of engagement described as more personal human connections were attained. When nurses’, patients’ and families’ efforts to manage relationships achieved more personal connections, they expressed satisfaction. Being satisfied included a heightened sense of trust and respect, acting in reciprocal ways, and better care outcomes. Patients and family members experienced a greater sense of well-being, while nurses described feeling they had done their jobs well and all groups described ‘doing the job with heart’.

The process of progressively engaging occurs during acute illness episodes in hospital. Because nurses provide care to all hospitalized patients, some level of engagement occurs between them and their patients in the process of providing care. In some contexts, where patients are unconscious or less able to actively participate in managing relationships, nurses acknowledged an increased need for nurse-family engagement. The goal of progressively engaging was to provide care that promotes patient and family well-being and enhances nurses’ satisfaction in a job well done.
Many participants described nurses, patients, and family members managing their relationships so that they achieved a more personal level of engagement over time. Progressively engaging consisted of acts of coming together where nurses, patients, and family members moved forward on a trajectory of engagement; however, at any time nurses, patients, or family members could step back from active participation and move backward on the trajectory. Managing their relationships to try to achieve personal connections in the context of care in acute care hospital settings facilitated progressively engaging.

Participants indicated that progressively engaging did not always occur. Nurses, patient, and family members maintained lower levels of engagement or stepped back from personal connections in response to systemic structural conditions, such as staffing shortages, or contextual structural conditions such as family not being present; personal factors such as attitudes and values held by nurses, patients, and family members that limited their desire to seek personal connections; and negative interpersonal dynamics occurring within the relationship. Nurses', patients' and family members' positive responses to structural conditions, personal factors, and interpersonal dynamics facilitated their efforts to achieve higher levels of engagement.

5.3 Stages of Engaging

The process of progressively engaging includes stages of nurse, patient, and family interaction that can be characterized as progressively higher levels of engagement. The engagement trajectory reflects a lower level of personal connection at one end through to a higher level of personal connection at the other. Nurses, patients, and family members managed relationships by moving up or down the trajectory. If they moved down the trajectory by stepping back, there was the potential for families and patients to fall through the cracks or go
unnoticed except for receiving the most basic care in the form of task completion (see figure 1.0).

The level of engagement attained when managing relationships depended on how nurses, patients, and family members individually and collectively perceived structural conditions and personal factors at any stage in the process. If nurses, patients, and family members perceived

**Figure 1.0. Progressively Engaging Process.**

Legend: N - nurse; F - family; P - patient
structural conditions and personal factors as favorable to managing relationships, they were more likely to pursue more personal connections, which moved their relationship to higher levels of engagement. As nurses, patients, and family members progressed along the trajectory toward higher levels of engagement their relationships became warmer and more reciprocal (Figure 1.0). Alternatively, when nurses, patients and family members perceived structural conditions and personal factors as unfavorable to managing their relationships they did not pursue more personal connections. They could not only resist moving to higher levels of engagement, but could also step back from active participation and commitment to each other and move to a lower stage of engagement. In those cases their relationships were characterized by impersonal, business-like and sometimes discordant interactions.

The three stages of engagement in the progressively engaging process include: focusing on tasks, getting acquainted, and establishing rapport. These stages capture nurses’, patients’ and family member’s efforts to manage their relationships. Each stage of managing relationships is depicted in Figure 2.0. In the section that follows, I provide a brief overview of the stages of the process of progressively engaging.

5.3.1 Stage one: Focusing on tasks.

Focusing on tasks refers to the stage of minimal engagement. During this stage, nurses completed tasks that had to be done for the patient, such as administering medications, monitoring equipment, attending to basic physical needs of patients (e.g. feeding and bathing), and completing necessary documentation without acknowledging the recipients of care. Patients and family members focused on the competence with which nurses undertook the skills necessary to care for them and/or their ill family member. Interaction between nurses and
patients and family members was minimal and guarded. Any conversation tended to be patient-focused.

At this stage, negative structural conditions and personal factors influenced the nurses’, patients’, and family members’ management of their relationships by reducing the likelihood that they would move beyond focusing on tasks as a basis for interactions. If the terms of engagement were negative and were, in turn, followed by negative interpersonal dynamics, managing relationships at this stage was difficult and participants could step back from and/or opt out of the relationship altogether. Negative structural conditions included, for example, staff shortages. Personal factors pertained to a general lack of personal motivation on the part of the participants to pursue more personal connections for reasons such as previous bad experiences and personality traits.

If, while completing nursing tasks, there were positive conditions that permitted the investment of time, and personal factors such as motivation, nurses, patients, and family members were more likely to move beyond a task focus as a basis for interaction to feel each other out. If while ‘getting a feel for each other’ the exchange of more personal information resulted in positive interpersonal dynamics, the group was more likely to move forward to the next stage of getting acquainted. If there were negative interpersonal dynamics, the group stayed at the impersonal or business-like level of interaction or “just doing the job”. Moreover, if conditions and personal factors led to negative interpersonal dynamics, nurses, patients and family members could disengage even further and patients and family members “fell through the cracks”. Falling through the cracks described managing relationships in ways where there were no attempts by the nurse to engage or interact beyond attending to basic physical care and medical monitoring needs.
Nurse, patient, and family relationships:

Stage 1: Focusing on Tasks

Just doing the job

Negative interpersonal dynamics

Stage 2: Getting Acquainted

Doing the job

Positive interpersonal dynamics

Stage 3: Establishing Rapport

With heart

Negative interpersonal dynamics

Progressively Engaging
When the way in which nurses, patients, and family members managed their relationships was characterized as 'just doing the job', with neutral or negative interpersonal dynamics, they described feeling dissatisfied because they felt disrespected, unappreciated, and undervalued. When getting an initial feel for each other was characterized by positive interpersonal dynamics they managed their relationships by investing more time and energy in order to get acquainted. In other words, initial interactions during focusing on tasks which demonstrated interest and concern for each other in relationship increased the likelihood that nurses, patients, and family members would move to a higher stage of engagement.

5.3.2 Stage two: Getting acquainted.

When interest and concern for other(s) characterized interpersonal dynamics, the nurses, patients, and family members managed relationships by moving into the getting acquainted stage of progressively engaging. In this stage, the participants took further tentative steps towards getting to know each other. Nurses in this stage shared their values for attending to personal elements of their patients and their patients’ families in their care. They believed that undertaking tasks with patients and families did not exclude getting to know them; they could accomplish both outcomes during their time with them.

Patients and families who were willing to move to the stage of getting acquainted were building on their perceptions of nurses’ competence and their feelings of good will towards nurses in general. Family members and patients who found that nurses persisted in focusing on tasks and resisted their efforts to seek more meaningful levels of interaction stepped back from getting acquainted. Getting acquainted was very sensitive to nursing decisions related to the allocation of time, especially in response to sicker patients. Consequently, regardless of nurses’, patients’, and families’ good intentions to seek more meaningful levels of interaction, their
efforts could be derailed by structural conditions such as staff shortages, high workload, and high levels of patient acuity.

When time was invested in getting acquainted the technical focus of nurses, patients, and family members was reduced and more personal details were shared. At this stage, sharing personal details was equated with positive interpersonal dynamics and there was the potential for participants to move toward greater feelings of respect and trust. As nurses, patients, and family members began to trust and respect each other, they were more likely to manage their relationships by moving to establishing rapport, the next stage in the process. If getting acquainted was characterized by negative interpersonal dynamics, which inhibited the development of feelings of respect and trust for each other, any or all of the participants could step back from that stage in the relationship and move backwards on the trajectory to focusing on tasks. Very negative interpersonal dynamics such as being antagonistic could result in one or more participants opting out of the relationship.

5.3.3 Stage three: Establishing rapport.

The third stage of progressively engaging is ‘establishing rapport’. Establishing rapport represented the highest level of engagement in the progressively engaging process and was characterized by establishing mutual trust and respect between nurses, patients, and/or family members in relationship. At this stage, interactions were more reciprocal in nature, where nurses, patients, and family members shared gestures of recognition and support.

Establishing rapport was also influenced by interpersonal dynamics. Depending on the degree of success nurses, patients, and/or family members in relationship had in establishing rapport with one another, trust, respect and reciprocity within the relationship could continue to be enhanced through positive interpersonal dynamics, could stay the same through civil
interpersonal dynamics, or could deteriorate through negative interpersonal dynamics. If trust, reciprocity, and respect were enhanced, participants were all more likely to add the personal touch to care-giving interactions or “go the extra mile”. In terms of nurses, this involved acts such as spontaneously providing additional information to patients and/or families; bending the rules; spending time ‘chatting’ or providing ‘extra’ (beyond that which is required) care. Patients and family members described adding the personal touch or ‘going the extra mile’ by being more tolerant of nurses’ other activities, being more willing to help themselves or their ill family member, being respectful and cooperative with nurses, cutting the nurses ‘lots of slack’, and following hospital policies and routines. When nurses, patients, and family members managed relationships by being receptive to and reciprocating each other’s efforts to engage, a positive cycle of rapport building occurred. All the participants referred to this as “doing the job with heart”.

The theoretical overview of progressively engaging has described how nurses, patients, and family members managed relationships in the course of patient care with varying levels of involvement depending on conditions. Progressively engaging represents an ideal trajectory of engagement. The outcome can be nurses just doing the job at one end of the engagement continuum through to nurses doing the job with heart at the other end. It is toward a more detailed description of the stages of the progressively engaging process that the focus of this chapter now turns.

5.4 Grounded Theory: The Progressively Engaging Process

5.4.1 Stage one: Focusing on tasks.

When nurses, patients, and family members initially come together in relationship in acute care hospital settings, it is around the patient’s illness episode. The specific focus of interaction
is typically directed at doing the tasks associated with physical and medical care delivery as dictated by the patient’s illness status. As the nurse, patient, and family engage around patient care their interactions are influenced by structural conditions and personal factors operating external to and within their relationships. Each individual’s response to these conditions and factors affects how they perceive one another in the relationship, which, in turn, influences decisions around how they manage their relationships with each other.

5.4.2 Structural conditions and personal factors.

Social structural conditions affecting nurse, patient, and family relationships identified in the acute care settings were systemic or contextual in nature. Contextual conditions referred to unique circumstances that were specific to the nurse’s, patient’s and/or family member’s interactions. For example, in the event of a patient lacking family support, nurses indicated they were more inclined to seek personal connections, thereby increasing the likelihood of achieving a higher level of engagement.

Sometimes the acuteness of their disease [determines the kind of interaction] and then the other factor I guess would be whether that patient has and receives a lot of visitors during the day. You know? If they do then they aren’t prone to feeling cooped up, depressed or whatever in the hospital because they always have visitors. So this one fellow doesn’t have visitors at all so I just have to allow extra time with him (N-16).

Systemic conditions referred to organizational or operating conditions that affected nurses’ work in acute care hospitals. For example, the chronic shortage of acute care nurses and insufficient numbers of long-term and palliative care community facilities contributed to high patient acuity and increased the numbers of palliative and long-term care patients on acute medical/surgical hospital units. Having higher levels of palliative and long-term care patients created higher nursing workloads, which indirectly affected nurses’ efforts to provide patient/family care and engage in nurse-patient and/or family interactions. Such conditions could
prevent nurse, patient, and/or family relationships from moving beyond focusing on tasks or could contribute to negative interpersonal dynamics leading to stepping back from or opting out of relationships.

Although several nurse, patient, and family member participants commented that they believed nursing shortages were common in the acute care hospital setting, participant observation on the nursing units indicated that the incidence of a nursing unit being short staffed on any given day varied. Similarly, while patient acuity was commonly expressed as a problem of increasing magnitude resulting in chronically high nurse workloads, I observed that the nursing unit acuity level also varied. The nurses indicated that their perceptions of unit acuity depended on their perceptions of nurse workload and staffing levels. The variable nature of conditions was described by nurse participant 06 as follows:

\[\text{You can plan and kinda expect what your day is going to be like but every day is different. You might have a new admission that is having a lot of pain, a palliative patient who requires more care, or some days are absolutely crazy days and you can’t put your finger on why. Other days it is quiet and calm and once again you don’t really see anything different it’s just the feeling or the atmosphere on the unit. It varies so much from day to day you can’t say ok, tomorrow I am going to be able to sit down and talk with the family ‘cause tomorrow just might not happen; you can’t plan because every day is just so different.}\]

Although conditions varied, ultimately, it was the meaning assigned to the conditions by the nurses, patients, and family members and how these meanings fit together that influenced interactions within the nurse-patient/family relationships.

Personal factors also affected nurse, patient, and family interactions. Personal factors included attitudes and values held by nurses, patients, and family members about the desirability of seeking personal connections, as well as non-verbal forms of communication such as smiling when entering the room. Verbal forms of communication or the manner of speech used affected interactions. When, for example, responses were perceived as abrupt or indifferent, participants’
willingness to get to know each other decreased and the focus of interaction remained limited to
the provision of physical/medical care and assessment tasks - especially if nurses perceived that
they were busy.

When time was viewed as constrained, interaction with patients and especially family
members beyond tasks for patient physical/medical care needs was perceived by these nurses as
a "luxury". In other words, skill competencies and patient/family interaction seemed to be
regarded by many of these nurses as mutually exclusive activities. For example, in comparing
their work as former nurses on a busy medical unit with their work in a community hospital
intensive care unit (ICU), nurse participants 04 and 05 agreed that workload negatively affects
nurse-patient and/or family interaction. As these participants explained, nurses who have fewer
patients to look after (as is usually the case in the ICU) are more likely to have the luxury of time
to interact with patients and families.

N-05: [As a medical nurse] I’ve got to make sure they are bathed. I’ve got to make sure
they are fed. I’ve got to get their meds out; god, they better not ask me about explaining
this or that because it’s hectic. N-04: And it’s a fast answer to get out of the room because
you’ve got other things to do. N-05: yeah, and here [in the ICU] we’ve had the luxury, the
luxury of talking to my patient’s daughter today because that’s what it [interaction] has
become [a luxury]. We can be very busy. N-04: yep, a luxury. She [the other nurse] has too
many [patients]...N-05: yeah 1, 2, 3, she has 4 patients which is too much this morning so
she has been very task oriented and hasn’t had any time and I think she even had to tell
them [family] on the phone “I don’t have time for this now so I am going to have to call
you back”.

5.4.3 Terms of engagement.

The terms of engagement were the conditions (contextual and systemic) and personal factors
that were present when the nurse, patient, and/or family member first came together. For
example, nurses indicated that when they were busy providing priority physical/medical care to
patients they were less likely to pursue personal connections with family members. In fact,
many nurse participants suggested that limiting their interaction with family was justified
because patient care was considered the priority. Nurse participant 01, for example, believed that
because patient care came first the needs of family members were ‘fit in’ if time allowed. She
stated:

...the families and perhaps their needs fit in if...I mean they can be part of that
but they are not going to be a high priority you know? I mean, they most
certainly are needed but it’s not something that’s going to be high on the list
when it comes to patient care. There’s the sad story at the end of it all.

Terms of engagement represented the circumstances for interactions and influenced whether
the group stayed at focusing on tasks. Terms of engagement could be perceived as negative or
positive or somewhere in between. If they were negative, conditions and personal factors aligned
to discourage nurses’, patients’, and family members’ efforts to interact with each other. If the
terms of engagement were perceived positively, the conditions and personal factors encouraged
efforts to interact and set up the possibility for positive interpersonal dynamics. They initially
affected decisions about why, how, when, and with whom the participants interacted, as well as
the basis for interactions. The terms of engagement only set the stage for focusing on tasks,
because, after initiating interactions, the interpersonal dynamics became more central to whether
nurses, patients, and families were able to move beyond focusing on tasks.

Patients, family members and particularly nurse participants emphasized three main terms of
engagement that influenced how they initially managed their relationships at the focusing on
tasks stage. The first was the perception of time, which was affected by structural conditions
such as short staffing, nurse workload, and acuity. The second term of engagement was the
perception of language barriers. The third related to the perception of patient/family cooperation
and compliance.
5.4.4 Perception of time.

Some nurses linked being less busy with having fewer patient physical/medical care tasks which, in turn, meant that they could allocate more time to getting to know patients and family members; however, this was not consistently the case. Several nurse participants acknowledged that establishing more personal connections was important to establishing trust in the nurses-patient/family relationship and contributed to more positive patient outcomes; however, they did not necessarily invest available time in getting to know patients and family – at least not all patients and their families. This was because decisions around allocation of nursing time were influenced by the meaning nurses gave patient acuity. For example, nurse participant 09 stated:

Because we have like one nurse to eight patients with the LPN’s help [pause], if you have all extended care, that’s not too bad but if someone is really sick then our time is going to take care of that patient and then you don’t really have time to spare with the others.

When nurses had lighter patient loads (e.g. patients with fewer physical/medical care task requirements), they indicated they had justification for their time to be spent pursuing higher levels of engagement with palliative patients and their families, because they had an increased need for support. Nurses’ efforts to move beyond focusing on tasks with some patients/families depended on the meanings nurses assigned to patient acuity which influenced their time allocation decisions. Nurse participant 07 explained:

I was lucky enough on the night that I dealt with the couple that I had a light enough team in the sense of the needs of the 8 patients that I could spend time with that couple. But if I have one patient that is going sour then they get a lot of my time. So it totally depends on the mix of the patient profile and what is wrong with everybody.

Worsening patient conditions and staffing shortages imposed time limitations which affected nurses’ work. They focused on tasks or attended to priority physical/medical care needs of patients, because they regarded them as taking precedence. Thus, they ‘got the job done’ which
reduced their attention to personal connections with some patients and families, which kept them at lower levels of engagement with them.

During focusing on tasks, the meaning participants assigned to time influenced their decisions about interacting. Many nurse participants indicated that, in acute care hospital settings, they did not have time to manage all the demands placed on them. They viewed time as a limited resource, because they indicated they simply cannot be everywhere, be everything, or meet every need or expectation of every patient and family member in their care. Nurses described being forced to manage nursing time by focusing on meeting the physical and medical needs of patients rather than caring for patients holistically, with family members’ needs being even less of a priority.

Social structural conditions that reduced available time were nursing shortages and patients who were very acutely ill and required frequent assessments and care. The increased incidence of elderly, disabled patients (mentally and physically) who required intensive nursing care to meet their physical and medical care needs also forced nurses to manage time by focusing on care tasks. Nurses described pressure to facilitate patient turn-over being passed down through the ranks of hospital administration to the nursing unit level. Typically these pressures came in response to a “back log” (N-17) of patients in the emergency department waiting for acute care beds when there was nowhere to send the chronically ill patients.

Nurses linked demands for acute beds to patients being moved internally (e.g. to transition units) or discharged home or to care facilities too soon. The nurses considered rapid patient turnover a systemic condition that negatively influenced their interactions with patients and families because they did not have time or did not perceive the need to allocate time to getting to know the patients or families. One nurse participant for example, compared her role on the acute
care medical unit to that of a “traffic cop”. She stated:

   So that’s just...you’re a traffic cop...I feel that with the acuity of them and the coming and fast pace that we do, the so called fast pace on the medical floor, you don’t have time to really get to know them ‘cause I can come in from a Friday to a Monday and I’ll have ten new patients (N-17).

   The nurses indicated rapid patient turnover and high acuity created extreme workloads which resulted in them growing increasingly frustrated and resentful about the effects on patient care and how they spent their time. All of the nurses interviewed linked the demands placed upon them to lack of time in a day to meet their own or others’ expectations for medical care, which precluded time to provide support or get to know patients and their families. As nurse participant N-06 explained:

   Time. It is always so short staffed and sometimes its very heavy and you don’t have that time to really interact with the family depending on what day it is and how it is on the unit and if you have enough staff – sometimes you can spend more time with family and sometimes, because it’s just faster to work directly with the patients you can’t really include the families because you don’t have the opportunity.

   Transferring patients within the hospital environment and discharging them as quickly as possible resulted in reduced consistency in care, which created barriers to nurses, patients, and family members getting to know each other.

5.4.5 Language barriers.

   If nurses emphasizing their busyness also encountered contextual conditions such as language barriers, these negative terms of engagement created circumstances where nurses were less likely to move beyond focusing on tasks. Although many nurses described being able to overcome language barriers with patients by ‘doing actions; guiding them; showing them’ (N-15), language could be a contextual condition regarded as a “hindrance” (N-01) to nurse-patient interaction. Many nurse participants acknowledged that language barriers resulted in communication that was limited to communicating basic needs (i.e. eating and toileting), and took a lot of time.
Language barriers between the nurse and the patient increased the likelihood that nurses would engage with the family to get assistance. When family members acted as translators nurses were more likely to consider them allies in care, because they facilitated more effective and efficient communication between the nurse and the patient. As nurse participant 11 pointed out:

If it is somebody that uh, there is a cultural problem, and they don’t speak much of the language then if you have family members available of course you’ll get them to translate anything you know, and try to get through the important parts.

Nurses increased their engagement with family to enhance nurse-patient communication, which made their jobs easier by promoting better patient compliance. When nurses’ perceived patients and family members as compliant they were more inclined to pursue personal connections with them, which was linked to more positive patient and family member health outcomes.

Language also acted as a barrier to nurse-family interaction. Some nurse participants indicated that they tried to communicate with non-English speaking family; however, the time spent trying to communicate varied depending on other conditions. Some nurses described trying to the extent that the family members (or patients) were also willing to try. As one nurse participant described:

Well I try to spend a lot more time with family members if they speak English. You know, if I can communicate with them then I try to involve them um, sometimes they don’t try either so it makes it very hard for us to communicate plus they don’t really understand what is going on with the patient (N-14).

Patients and family members described language barriers negatively influencing nurse-patient/family engagement. Family member participant 04 indicated when nurses are busy they are less patient about communicating with patients and family members who do not speak English well. Family participant 04 states:
No, no they know it [that they don't speak English], they know it but sometimes they um, they were aware that um sometimes we don’t communicate so well especially the first week and uh, um, sometimes because of accent and the use of voice um because the way I use my voice sometimes can’t get it, uh huh, they will be sometimes if they are busy not patient sometimes, sometimes, yeah.

Some family member participants also reported that their poor command of the English language created a barrier to their asking questions. Family participant 04 suggested that nurses are “less patient to listen” and try to understand patients and family members for whom English is not their first language especially when the nurses are busy.

5.4.6 Patient/family cooperation/compliance.

Nurses described managing their relationships with patients and particularly, family members on the basis of how family members interacted with and supported the ill family member. If family members were demanding, argumentative, or did not conduct themselves in a manner that nurses expected they should while in hospital, nurses were less inclined to engage with them.

Nurse participant 06, for example described such families as “non helpful”. She stated:

Some family members just don’t understand the nursing process or just the overall process of the unit or the hospital. “Well, they did it like this on the other unit how come you are doing it different?” Well, everybody does it a little bit different. And some are very hard on not only the patients but also on the nursing staff. “Well, how come she is not getting any better? How come she’s not able to do this yet? How come she is not walking yet?” So, a lot of times family can be not very helpful.

According to nurse participant 03, nurses’ do not have time to deal with “dysfunctional” family dynamics. She stated:

There was some dysfunction and one of the doctors knew of this estranged daughter and when she came in the daughter was actually quite vocal about and, and asking like about when to visit and when not and there was, it was a certain point when we were getting busy in here and we don’t police visitors. Like, that was almost another step further you know? We didn’t have time to go there with them. It was like, ‘you guys have to take this outside because we’re trying to care for your sick mom and we can certainly assist you with [providing] a social worker’ but I don’t have the time to take it to that level of family nursing.
In another example, nurse participants 04 and 05 offered the following comments about family dysfunction:

N-04: I think you have to maybe diffuse something if something starts to escalate even if it means asking somebody to leave. N-05: or all of them. N-04: or asking them to leave if it is a dangerous dynamic. N-05: yeah, if it is impacting the patient at that moment. N-04: They brought those dynamics in; we didn’t create them so the family has to sort that out.

Consequently, when nurses, patients, and families are in the focusing on tasks stage, nurses are more likely to privilege patients over family members, and consider the provision of physical and medically designated patient care their priority. Moreover, nurses are less inclined to engage with family member(s) whom they perceive as contributing to a ‘dysfunctional’ family dynamic, because they do not regard it as their job.

5.5 Interpersonal Dynamics

If the nurses were less busy, encountered no language barriers, and regarded families and patients as engaging in their care, these positive terms of engagement created possibilities for positive interpersonal dynamics between nurses, patients, and family members. The terms of engagement were not deterministic. While initial positive interpersonal dynamics occurring around positive terms of engagement facilitated movement toward ‘feeling each other out’, a positive interpersonal dynamic could also contribute to nurses’, patients’, and/or families’ willingness to overcome negative terms of engagement to achieve a more personal connection. Initial negative interpersonal dynamics, on the other hand, could thwart efforts to move into getting a feel for each other, even though initial terms of engagement were positive. In these cases, patients and/or family member(s) fell through the cracks. When feeling each other out perpetuated a positive interpersonal dynamic, nurses, patients, and families were more likely to progress to the getting acquainted stage.
If feeling each other out resulted in a negative interpersonal dynamic, there was movement toward stepping back, and in the case of severely negative terms of engagement, opting out of the relationship. Patients and family members in this stage, for example, focused on determining the competence with which nurses provided care to them and/or their ill family member. Negative terms of engagement such as nurse busyness (absence from the bedside) or nurse abruptness or indifference during provision of care undermined the patients’ and family members’ confidence in the nurses’ competence. These patients and family members perceived those interpersonal dynamics as negative which prevented them from moving beyond impersonal exchanges. Moreover, lack of consistency in nurses providing care, which patients and family members referred to as nurses passing through or only being there for one shift, made it difficult for patient and family member participants to assess nurses’ competence so they felt comfortable moving into getting a feel for the nurses.

5.5.1 **Positive interpersonal dynamics.**

Positive interpersonal dynamics increased the likelihood of forward movement toward achieving personal connections. In the focusing on tasks stage, initial positive interpersonal dynamics between nurses, patients, and families increased the likelihood of movement toward getting a feel for each other. Reflecting on what was meaningful about their engagements with nurses, many patient and family member participants commented that they responded to friendliness. They identified friendliness both by non-verbal communication (e.g. smiling) and verbal communication (e.g. joking). For example, patient participant 04 stated: [if they have a] “cheery smile and aren’t grumpy about coming to work today, then you are more likely to interact with them”. Family participant 03 stated: “they [the nurses] are friendly; they’re polite; they try and cheer you; they’ve got a sense of humor which is good”.
When nurses perceived patients and families as friendly they were more likely to contribute to positive interpersonal dynamics which increased the likelihood of getting a feel for each other. The nurses tended to place greater emphasis on the expressions by patients and/or family members of appreciation for the nurses’ efforts. Nurses’ willingness to pursue more personal connections beyond focusing on the job was influenced by the degree of reciprocity that existed within the nurse-patient and family relationship in terms of respect and appreciation. As an example, nurse participant 04 described the following scenario:

They call you for something and your busy...I had one lady, gosh about 2-3 years ago now and um, she was kinda a difficult person. She had a broken ankle and ended up, well it doesn’t matter, but anyway she was incontinent of stool uh, all over the place. So I cleaned her up and I wasn’t impatient with her or anything it was just [frustrating] and after cleaning up all the laundry off the floor and putting it in the laundry basket she, this little voice in the bed said “thank you very much”. And it honest to god it totally changed the way I approached her and I didn’t mind cleaning up. She was in here, it wasn’t her fault she ended up in here or anything like that and she was absolutely helpless in that bed but it was I guess maybe it was busy but after that I sorta found time for her. You do when there is a bit of a reciprocal...we’re not hand maidens and we’re not waitresses and this is part of the job we do and we shouldn’t need thanks and that but it, it really makes a difference when we are not treated so indifferently.

Nurse participant 05 added: “yeah, and then that works from getting that [not being treated indifferently] from the family as well as the patient”.

In the case of language barriers, when nurses and patients/families tried to communicate with one another by using whatever means available all indicated that they were willing to engage so that they moved from just doing the job to trying to get acquainted. Nurses were also more inclined to pursue personal connections with family members when nurses noticed family members attempting to assist their ill family member, looking like they had questions or wanted assistance, or seeking equipment or care supplies in order to participate in care delivery. As nurse participant 14 explained:
I see attempts on trying to do things. I see them attempting to put people back to bed or I see attempts at trying to swing their legs out of bed or I see them attempt at looking at the bed to adjust it. So I see that they are trying to do something or they are looking for things. A lot of family too will say oh, can I have some towels to wash up my Mom so, you can see that they are willing to help.

Continued positive interpersonal dynamics resulted in willingness within the group to advance to stage two: getting acquainted.

5.5.2 Negative interpersonal dynamics.

Negative interpersonal dynamics created barriers that decreased the likelihood of attaining personal connections and prevented nurses, patients, and family members from moving beyond the focusing on tasks stage. In these cases, nurses, patients and family members described their relationship as “just doing the job” or “going through the motions”.

When, for example, nurses managed time by privileging nursing skills and tasks, they showed that they were unwilling to engage with patients and families beyond meeting the most basic physical/medical care needs of patients and the superficial exchange of information. Nurses who focused on limited time created barriers to more personal connections with patients and families and kept nurse-patient/family interaction minimal. Those nurses took on a more routine approach to their work and greater power and control over when and how nursing tasks were performed and who participated in care. Nurse participant 01 offered this perspective:

[There are some controls that we have to have] even dressings, you know? [Patients will say] “well, my visitor’s coming in now”. Well, you know, I have other things that I have to do… you have to prioritize your work. So, I mean, that’s part of us trying to do, care for more than one patient. So, I mean sometimes patients have to be flexible too – and say to family no you’ll have wait out there for 10 minutes, I have to do this dressing now. And most people are fine with that. Yeah, I don’t think that’s such a big deal. I think they realize when they come into hospital that some of their control is lost.

The interpersonal dynamic, during the focusing on tasks stage of engaging, was typically described as guarded and ‘business-like’ or impersonal in nature. Conversations tended to be
patient-focused. Interaction was limited to exchanges of impersonal information for example, nurses responding to patient’s and family member’s questions about nursing tasks or patient condition updates, or obtaining supplemental assessment data from patients and families that nurses needed for patient care delivery.

Patient and family member participants indicated that they were less likely to interact with nurses who had a business-like and impersonal manner. Patient participant 09 for example referred to this approach by nurses as “business-minded”; patient participant 06 called it “strictly business”. Family participant 01 stated:

Some [nurses] are more personable. It’s like anybody in life really. Some people, like, I like to talk a lot [laughs] but there are some people that you know just go in there and do their job and they, and they just say what they have to say, you know? And I suppose nurses are going to be professional first you know? And try to do their job correctly obviously, you know? But you still should have a little bit of PR and that, you know, to go with that.

Family member participants, therefore, did not evaluate nurses’ professionalism solely on the basis of their competence with skills and tasks but also on how they engaged with patients and families. So, while doing their job nurses’ interactions with patients and family members contributed to patients’ and family member’s views of nurses’ competence. ‘Good’ nurses project a personal quality that is inviting, friendly, and supportive while attending to the physical care aspect of the job.

For many patients and family members, nurses who were impersonal, business-minded or just doing the job were identified by the lack of personal acknowledgement they received from the nurse. This may simply be in the form of minimal interaction with the patient and/or family member or the lack of friendliness or expressed concern and interest they interpreted from nurses. For example, family participant 02 stated:
Umm, some of them are good at explaining what is going on and being very helpful where as others it’s just sorta ‘push you away’ – don’t have time to deal with you; don’t really care; don’t want to help; we are here to do our job and that’s it and any questions that you have aren’t worth answering’. [And] they are there to get their job done that’s it at this point sorta thing. And we are there [speaking about nurses] to do our job and get our pay cheque and we are not going to do anything other than that whereas others are willing to go out of their way to help you or just to do whatever they can for you.

In acute care hospital settings, questions were the most important signal nurses, and especially patients and family members, used to engage with the other in relationship. Without questions, signals to engage were minimal and patients and families were more likely to fall through the cracks. Nurses’, patients’, and family members’ perspectives situated asking questions as the primary mode for setting up positive dynamics between them.

Family members could initiate positive dynamics by seeking patient status updates and/or explanations of diagnosis, treatment, and nursing care. They posed questions to the nurse because, as several patient and family member participants expressed, nurses rarely offered this information. Patients and family members reported that the only way to get information was to ask. As family participant 02 stated: “But obviously, if you’re not going to ask questions, they’re not going to tell you and so I guess it is up to the individual”. Family participant 09 stated: “We [her brother and herself] didn’t know what was going on [with their mother’s care] but when we asked they [nurses] gave us answers and we both felt really good”.

My participant observation confirmed that patients and family members often initiated interaction by asking questions. Frequently, however, patient and/or family member questions were posed to the first available nurse who was not necessarily the nurse caring for them or their ill family member. This was done by the patient or family member approaching the nursing station and waiting to be acknowledged by one of the nurses. As family participant 08 explained: “They won’t come out and tell you [information]. I’ve had to go to the desk to find out”.
Patient and family member participants acknowledged that there were conditions that constrained their efforts or desire to ask nurses questions. Several patients and family members indicated that they felt intimidated by the hospital environment or by the nurse. Family participant 04 for example stated: “sometimes, if they are so busy and you ask too much then they feel maybe they feel you are annoying; they [nurses] have no time for us to ask some questions”. Others stated that they or other patients and family members might not know what questions to ask or how to ask them. Family participant 07 stated:

I know that they [nurses] are very busy and some people don’t know what kind of questions to ask either. And it [the hospital] is another world and if they’ve [patients and family members] not had exposure to it I think sometimes they wouldn’t know what to ask or even if they were told they wouldn’t understand.

When patients and families described nurses’ actions as expressing impatience they regarded the interpersonal dynamic as negative. They indicated that the nurses did not respect them or have time for them. In those cases, patients and family members stepped back from engagement because of a lack of self-confidence in their ability to communicate and fear of making the nurse angry by taking up nursing time.

Several patients and family members stated that nurse busyness was also a barrier to asking questions because they did not want to bother the nurse. For example, patient participant 07 stated: “Well, I just try not to ask for anything or bug them while they are busy. And if you just have to do it just make it as pleasant as you can for them and that way they won’t mind if you ask them again”. Family member 07 also indicated that she tried to not bother the nurses with questions when they were busy out of courtesy. She stated:

[When nurses are busy] I am inclined to not ask questions at all but I do ask the questions when I see they are not totally involved; I tend to wait [for an opportunity] you know? That is just a courtesy for one thing.
Nurses indicated that they set the terms and conditions for if and when it was appropriate to ask questions and controlled sharing information in response to questions. Many nurse participants expected that patients/families would ask questions while they were at the bedside for other reasons, e.g., performing assessments, giving out medications. They were not receptive to being called away from attending to other patients for the purpose of asking as questions, unless they linked questions to a major problem, for example, malfunctioning equipment, or a change in the patient’s condition. Nurse participant 08 stated:

Like the person that will buzz for assorted things, like they hear you in the room and they’re calling ‘nurse, nurse’ or they want a garbage bag or whatever and you’ve got somebody that’s not breathing in the other bed. So, if you know it is not important you just get them to wait and you’ll be in there to see them as soon as you can. You have to set limits too, I mean, just like children sometimes.

When nurses perceived too many false alarms (‘crying wolf’) they were more likely to step back by setting limits pertaining to appropriate reasons for calling the nurse, responding to calls slowly, or ignoring calls altogether.

5.6 Falling Through the Cracks

When patient or family participants responded to the terms of engagement by not viewing nurses as competent, or nurses viewed families and patients as failing to initiate interactions by questions (either through personal factors or language barriers) or being demanding and non-compliant, there was a failure to engage or nurses only provided physical care. Participants experiencing those circumstances were unwilling to move to ‘feeling each other out’. Feeling each other out was a necessary bridge to moving to the second stage of progressively engaging. Failure to engage was described by the participants as ‘falling through the cracks’. It resulted
from a general lack of interaction between nurses and patients or more commonly between nurses and family members, especially if family members were infrequently at the bedside.

Nurse participants indicated that they were unable to engage with families at more than the most superficial level if family visits were infrequent, short, or untimely as perceived by nurses (e.g. coming at change of shift when nurses perceive that they don’t have time to interact with family members). Nurse participant 08 explained: “Sometimes it’s hard for us to kinda see the family or be in the room at the same time the family is because sometimes they come in for brief visits”. Some nurses indicated that, because they believed that family visits were private matters, they did not want to interrupt. Others used family visiting times as an opportunity to focus on other patients and only to respond to questions from patients or families, because they believed that patients did not need them when family members were present. Nurse participant 12 stated: “If there is family at the bedside I usually let them visit; if the patient does not need me. If they need me they will ring”. Similarly, nurse participant 13 stated:

When there is a lot of family at the bedside who are, kinda helping with the patient and all that, I just say hi and do what I need to do and then go on to the next [patient]. Sometimes if the patient doesn’t want to talk or if it is too much for them you don’t know where they are at or what they need but if they start talking or ask questions you really know what information to give.

Family participant 02 also noted that nurses would often not interrupt when they were present:

Basically, I would say no [nurses don’t interact with her]. At times it could be because they [nurses] don’t want to interrupt. You know? You are here for a short time visiting and they don’t want to bother or interrupt a lot of the times I’m sure.

Several patient and family participants agreed that, when family members are at the bedside and nurses are busy, the nurses were less likely to initiate interactions. The participants seemed resigned to this lack of interaction. For example, patient participant 05 states:

Again, it’s about time for the nurses, it really is, because when the family members are around, in a way, it relieves the nurses a bit and they can spend a bit more time perhaps in
another room that they need to. You see what I am saying? They can back off because their
patient is sorta being looked after and they don’t ignore them; don’t misunderstand me, but
there hasn’t been a lot of interaction with the staff and family members.

From all of the participants’ perspectives, patients or family members were more likely to fall
through the cracks when nurses were busy and used family presence as an opportunity to be
absent from the bedside.

Nurses also described choosing not to communicate with patients and family members
because they were busy or not motivated that day (e.g. stressed; low energy). Unless family
members and patients initiated interactions, they fell through the cracks. Nurse participant 07
offered the following perspective: “They [patients and family members] you know, just kinda
disappear and try and make themselves invisible…and those are the people that I think get
missed a lot…and the communication just isn’t going to be there”. Family participant 01
indicated that she perceived she was not noticed and/or needed by the nurse. She stated:

I was sitting there and nobody really addressed me at all to ask me any questions or
anything like that you know. I just sat there until the nurse came in there to do anything
and I kinda moved out of the way because obviously you know, they have to handle it but I
wasn’t asked to do anything or they never really chatted to me specifically. But then I
really didn’t expect it to be honest because I know how busy nurses are and it’s not that
they have time to chit chat…and perhaps it depends on the type of surgery. If he was more
ill I would expect a bit more rapport with them.

Falling through the cracks appeared to result when nurses, patients, and family members were
all waiting for the other to signal a willingness to engage, but no one did. Patient and family
member participants indicated when nurses were perceived to be too busy, patients and family
members forfeited initiating or taking advantage of opportunities to interact with nurses. Patient
participant 09 stated:

Maybe some [nurses] just spend a little more time than others but I think they are more like
business minded I guess. The reason why that might be is because I am not a very talkative
person, you know? I am not very socializing [sic]. I am not very talkative so I don’t talk to
them very much so yeah…and I notice that they don’t want to push it.
When patients and/or family members did not ask nurses questions or communicate about their needs, nurses described viewing them as a lesser priority and allocating their time to others that they perceived as being in need of services.

When patients and family members did not make an effort to communicate, nurses were more inclined to regard them as uncooperative and/or distrustful. Other nurse participants indicated that when family members do not speak English they often fell through the cracks because the nurse decided not to take the time needed to try to communicate. When nurses did not invest time to try to communicate patients and family members were more inclined to perceive them as just doing the job and were less motivated to engage in interaction with them let alone pursue more personal connections.

When family members perceived the patient’s illness to be less serious than those of other patients and there was increased patient independence with self-care, they indicated they understood that their care needs were a lower priority and there were fewer tasks around which nurses, patients, and family members engaged. Fewer tasks were interpreted by some nurses to mean that there was less need to interact. Nurse participant 16 stated: “...and especially if they [patients] are self-care then they do fall through the cracks because they are fine and they can look after themselves, in fact, you can get up and you can help your neighbor next door kinda thing”.

With negative initial terms of engagement and negative interpersonal dynamics, nurses opted out and family members indicated they preferred opting out. Under negative terms of engagement and absent interpersonal dynamics, patients and family members described falling through the cracks. In circumstances where initial terms of engagement were positive followed by negative interpersonal dynamics, nurses, patients, and family members described stepping
back. On the other hand, in cases where terms of engagement were positive and followed by positive interpersonal dynamics, the participants moved on to feeling each other out. This could also occur in circumstances where the initial terms of engagement were negative but the positive interpersonal dynamics allowed the participants to move the relationship forward.

When nurses managed relationships by focusing on tasks and enforcing a routine approach to care, family members perceived them as disrespectful. Family participant 10 stated:

I won’t be happy if my family [member] comes into hospital. I am saying that they [nurses] don’t put their mind in our position to thinking how we think. They just say: ‘I have to do that’; ‘I have to put the needle; I have no time; I have to go lunch. I have to do it now’. But sometimes, let’s say example, because the patient’s sleeping, the lunch here or something here, so I said: can you wait for little bit ‘cause she just sleep? You know, she so tired; let her rest or maybe afterward I can look after this and that, but some isn’t happy because they think ‘oh, later on is my lunch hour’. Later on, cannot come back at noon, let me do it now. You know? Things like that. And I don’t think that is necessary except the medication is very important right on the time. You have to, the patient have to take it - that I understand but I know some have an easement but some don’t let you because they know that the power is on them because they are nurse. You know, if they say you can’t, you cannot fight with them. Isn’t it right? So, but I know, you know sometimes they don’t just what I described that, that they don’t use heart to do things.

Focusing on tasks to the exclusion of attending to individual patient/family differences conveys a message to patients and families that nurses are not interested or are unwilling to get to know the patient and/or family. In turn, patients and family members are more likely to feel undervalued – that their care and concerns are inconsequential to nurses. Such feelings were expressed by patients and family participants as “just a number” or “just another patient” and were linked to disrespect and mistrust in the nurse-patient/family relationship. These dynamics limited motivation on the part of patients or family members to pursue more personal connections with the nurse and led patients and families to step back from interactions with the nurse. Any effort to feel each other out to move beyond the focusing on tasks stage of engaging ceased.
5.6 Feeling Each Other Out

If the terms of engagement when nurses, patients and families initially came together were positive and there were positive interpersonal dynamics, they expressed more motivation to interact with each other and feel each other out. Feeling each other out was characterized by efforts on the part of the nurse, the patient, and the family members to get a sense of others’ responses to conditions and personal factors. Information they obtained from feeling each other out influenced decisions about how they managed their relationships. Nurse participants frequently referred to this form of interaction as “assessing as you go” (N-06). Some nurse participants such as 04 and 05 referred to their efforts to ‘try and get them [patients and family members] to talk’ while they were performing nursing care task in order to get a feel for what is happening. Nurse participant 05 stated: “I just try and get them to talk, you know? And I guess the time when people talk, within ten minutes you probably get a good feel of what is happening”. One patient participant 05 referred to it as a time when the nurses are “still learning where I am at”.

Individual interpretations of and responses to others were expressed through interpersonal dynamics. Interpersonal dynamics influenced the level of engagement because they increased or decreased the likelihood of moving forward or backward through the stages of progressively engaging. When interpersonal dynamics were perceived positively, nurses, patients, and family members managed their relationships by moving beyond focusing on tasks as the basis for interaction to try to pursue more personal connections. They were more open to getting to know each other and to sharing details about their lives which increased the likelihood that they would move to getting acquainted.
Nurses also acknowledged that they interacted with some family members more than others, which suggested that nurses’ decisions about interacting were influenced by how they prioritized the perceived needs of family members. If while getting a feel for the family, nurses perceived family members to be supportive of the patient, they were more likely to interact with them. Nursing assessments of family support took into account such factors as the frequency of family visits, family members’ efforts to assist with patient care, family members’ willingness to ask questions or otherwise indicate their interest and concern, and their willingness to be ‘helpful’ to the patient’s recovery process. As nurse participant 06 described:

You just assess as you go you know? Are they very demanding? Do they appear helpful with their significant other or are they pushing them? Or, just how do they interact with the significant other? That’s a big thing...complaining.

So, although many nurse participants expressed the belief that working with family members is important to achieving the ultimate goal of “get[ting] the patient back to the highest level of health and independence possible” (N-06), this only held true if the family was present, supportive, and cooperative with hospital routines, and nursing care. As nurse participant N-001 maintained, families have to take more responsibility for supporting their ill family member while they are in hospital and after they are discharged. She stated:

I feel that families have to step in more and be that support. I mean, people’s lives are so busy; mom and dad are working besides they have kids, they’ve got parents. I don’t know what the answer is and how it can all fit in but I think families are going to have to step in and be more responsible and accountable to those patients (N-01).

When interpersonal dynamics were perceived negatively, nurses, patients, and/or family members were more likely to limit their interactions with each other. They lost their motivation to share personal information. They either stayed at focusing on tasks or regressed (stepped back). At the focusing on task stage, stepping back could result in absolutely minimal levels of interaction, with no efforts to feel each other out. In some cases, very negative interpersonal
dynamics resulting from the meaning assigned to certain conditions and factors by the
participants resulted in one or all of them opting out of the relationship altogether.

5.7 Stepping Back

Stepping back was a purposeful partial withdrawal from nurse-patient and/or family
interaction in response to negative interpersonal dynamics. Although nurses, patients, and family
members could step back from interaction at any stage of the progressively engaging process,
they were most likely to step back in the focusing on tasks stage when their relationships were
not characterized by any respect, trust, and reciprocity. While nurses, patients, and family
members could create barriers to interactions that caused one or more party to step back,
typically it was the nurse who stepped back.

When nurses stepped back from interpersonal dynamics their interactions were business­
like and impersonal conversations that focused on the provision of physical and medical care and
the superficial exchange of information. There was no motivation or willingness to pursue more
personal connections and feeling each other out ceased. According to nurse participants, actions
that signaled stepping back by nurses included: “putting their foot down” (N-013), “drawing the
line” or setting limits (N-007), “not doing that little bit extra” (N-004, N-005), and “just doing
what they have to do and go on to the next” (N-010, N-002), “ignoring” (N-016). As nurse
participant 10 described:

I do what I need to do for the patient and for the family...I try to do what I need to do and
get out and then I go to the next [patient]... I’ll address their issues in the same way that I
address other people but it is just a different atmosphere.

Similarly, nurse participant 14 explained:

I am probably a little more assertive or a little, I don’t want to say short but I am very
matter of fact in my language and body language is too. I do what I need to do and then if
they’re satisfied or not satisfied, I don’t compromise my level of care, that is still
maintained but I am just very short and just do what I need to and then I leave. I mean, I do
still ask is there anything else I can do you know, and I try to make everything at least satisfactory for them and then I step back.

Although opting out of the relationship did not happen often, when interpersonal dynamics were really difficult nurses, patients, and family members opted out. As nurse participant 01 explained: “Sometimes patients and nurses don’t get along but then we try to switch that up very quickly. For whatever reason they have clashed and then we just change the assignment and let somebody else deal with it”.

Nurses indicated that negative interpersonal dynamics, which caused them to step back from personal connections with patients and family members, resulted when patients and/or family members expected or demanded attention which monopolized nursing time beyond what nurses believed was reasonable. Typically nurses regarded these patients and family members as overusing or misusing the call bell (e.g. to fluff their pillow; ‘crying wolf’ behavior) or repeatedly making demands at times that nurses perceive to be inconvenient (e.g. when they are busy with another patient or during shift change). Nurses stepped back from personal connections with these patients or families, because they were worried that other patients and families may feel neglected; they perceived them as a barrier to completing their work (especially when priority is given to skill competencies and tasks); they perceived other patients and families to be in greater need e.g. sicker patients; or they felt frustrated by a lack of appreciation for their previous attention.

Nurses gave the most common reason for stepping back as feeling disrespected and undervalued (made to feel like “handmaidens”). Those relationships from the nurses’ perspectives lacked reciprocity or as nurse participant 12 put it: “they [disrespectful] patients and family members suck out my soul, you know? They take my spirit away from me”. In another example, nurse participant 14 stated:
There are patients and family members like that demand more time than they are given. And I think that they come in with higher expectations than what they get. I can only speak for myself and I do the best I can and provide the best information I can but sometimes that still is not good enough but I can’t do anything more than that. [And] when I think I have exceeded my limits regarding care, information, assisting, everything I do; when I know I’ve reached my limits and I know I can’t go any further or I realize that I am neglecting other patients, then I have to step back and I have to let them know that this is all I can do and I am neglecting everybody else.

Often nurses described demanding behavior by patients and/or family members as an indication that they ‘just don’t understand how hospitals work these days’. Due to a lack of understanding or inexperience with hospitals, patients and families may have held nurses to a standard of care that nurses believed they could not meet given the multiple demands on their time. As nurse participant 17 pointed out, “I think they want things to happen, done yesterday, you know? …Well, it just doesn’t work quite so fast but it will, things will get done”. It also depends on patients and families expectations. Nurse participant 04 and 05 stated:

Here [ICU] we [nurses] have much more power. We have knowledge; we control the machines...so we get much more respect, more please and thank you’s than medical nursing where they [patient and family members] think all you do is take BP’s, give out pills, and take care of IV’s but you are running for everything. It depends on the family’s expectations and sometimes they expect more of the nurses when their family member starts to go down the tubes and they get angry when they think their family member is not getting what they think is the best care.

When patients and families convey poor understanding about health care challenges affecting nurses’ work and hold nurses to unrealistic expectations, nurses are more inclined to perceive them as disrespectful. In these cases, nurses described feeling resentment about patient/family requests that they considered unimportant. Although some nurses made an effort to orientate clients to hospital policies, routines, and reasons behind certain decisions, they ultimately resented time spent doing ‘public relations work’ and became less motivated to pursue more personal connections. As nurse participant 13 explained:
When it comes to family interactions, you meet a lot of resistance, like why is my mother in a room with two other men. So there is an awful lot of, I'd like to say education but you know, to be honest I think it's uh, PR...I am very sorry but that is the way it is and we don't have another bed to facilitate an all female room and gone are the days when we had the room to be free with putting all females or all males in. Now we are so lean, they go where you put them and that's it and I, often times you feel like saying at least she's got a bed! ...'cause that's the bottom line. Which would actually take me away from the real issue - that you need to be spending time with them because you are concentrating on issues that you really shouldn't need to be concentrating on.

Nurses also stepped back from personal connections when patients or family members undermined or challenged their knowledge, skill, or judgment or were non-compliant with their or other members of the health care team’s requests. In describing their response to patients who are non-compliant and are perceived as not taking responsibility for their own health, nurse participants 05 and 04 stated:

N-05: You know anyone that wants to help themselves and they are trying, you’ll try. But as soon as somebody does something, you know, behavior that is totally stupid and that is just going to harm them [example given was smoking after a major heart attack], you step back. That’s what I do. N-04: I always tell people we offer advice but it is up to you what you do with it and they are not in jail here...N-05: [it is an issue of] taking responsibility for their body, I mean, they're handing it over and that angers me. N-04: Yes, it's very frustrating. N-05: So you withdraw. N-05: You withdraw emotionally. I like to think not in care but emotionally and you might not be as willing to volunteer information or you know, “oh, I’ll go search for that pamphlet”. N-04: Because they don’t care. They don’t care so why should I? N-05: I’ve got other people that, you know, there are always other people that need your time and your comfort. N-04: ...if the family member is silly too [non-compliant] then you go (rolls eyes) you know? They need to give their head a shake. It is hard to get in the game with someone who doesn’t want to play ball.

Nurses also stepped back when patients or family members were regarded as overly aggressive or threatening in their interactions with nurses or other patients and families. As nurse participant 07 described: “If they take a real defensive stance then they will be in your face; they’ll be aggressive. Aggressive and just in your face in the wrong way”. Nurses’ reasons stepping back in such cases may include: self-preservation (avoiding angry clients; protecting
their sense of self-confidence and self-worth in a job well done) and believing that the behavior is counter-productive to the well-being of self and others.

Nurse participant 09 commented that when family members come at busy times, nurses are not inclined to invest time to interact with them.

The family just comes at supper time because they are working and that time is the busiest time. Suppertime arrives at 6 o’clock and we are almost the end of the shift and trying to finish our paperwork or anything and sometimes you just say hi, you really don’t know the people. I see the patient has some visitors but I don’t have time to really go around (N-09).

Many nurses indicated that when family members opposed or ignored patient’s wishes or when their actions were not perceived to be in the best interest of the patient, nurses stepped back from personal connections with them. Nurse participant 13 stated that what “bugged her the most” was when family members fail to see that they are “not giving what is best for the patient; they may be giving what is best for them, or doing what is best for them and comforting themselves” but not the patient. Nurse participant 02 maintained that nurses are the voice of the patient: the nurses’ role is to advocate on the patient’s behalf which sometimes puts them in an adversarial position with family. Nurse participant 02 stated:

I mean, it does involve the family but quite often you do have to say to the family, perhaps your father doesn’t want this or perhaps your mother has got other ideas. And sometimes family are adamant – No! They want everything done. And I say well maybe that’s not your decision to make; perhaps it is your father’s or your mother’s.

Similarly, when family members’ efforts to support or be involved in the care of their ill family member was perceived by the nurse to be inconsistent with what the nurse believed was in the best interest of the patient, the nurse was more likely to step back from personal connections with family members. For example, when family members persisted in following certain cultural practices and beliefs or “different ways that families treat their patients [ill family
member] that keep them a patient longer” (N-16), nurses would manage their relationships with them by stepping back or opting out of more personal interaction.

When family members were perceived by nurses to be obstructive to patient care, unsupportive of nurse’s efforts to provide care, or conveying disrespect for either the patient or the nurse, nurses were more inclined to step back from interaction with them. Nurses viewed family members as disrespectful when they held unrealistic expectations around care for their ill family member, expected the nurse to be the sole provider of care, and showed little if any initiative to participate in care – even simply asking questions. For example, nurse participant 12 believed family members were disrespectful of their ill family member when they ignored hospital policies and routines by coming to ‘visit’ at all hours of the day and night and/or staying too long and disrupting the patient’s rest:

Now you’re up working nights and people just wander in at 10:30, 11:00 at night and it is disruptive to the patients because they are settled by 10:00 at night but they’ll [family members] will walk into a 4-bed room, they have no qualms. They don’t even stop at the desk and say “I need to see so and so. Gee could you check and see if he’s asleep or do you mind?”

Nurse participants 04 and 05 described non-helpful family members who do not support their ill family members in their effort to improve their health. For example, they regarded a family member who continued to smoke heavily in the presence of an ill family member/patient with serious cardiac disease as unsupportive.

5.8 Just Doing the Job as Outcome

Patients and family members were more likely to step back from interactions with nurses whom they perceived to be ‘just doing the job’. Just doing the job or going through the motions was the outcome of neutral or negative interpersonal dynamics associated with the focusing on tasks stage of progressively engaging. Because negative interpersonal dynamics resulted in a
decreased willingness to pursue more personal connections, it could be associated with nurse-patient and/or family interactions being ‘stuck’ in the focusing on tasks stage, without any forward or backward movement on the progressively engaging trajectory. More often it resulted in patients and families stepping back or opting out of interaction, because they distrusted the nurses and felt disrespected by them. For example, patients and families perceived that nurses were just doing the job, because they did not follow through with promises, seemed to put other tasks ahead of patient care, or followed routines without consideration for individual differences. Patient participant 13 offered the following description:

Well, I trust but I don’t trust everything they say. For example, I’ll be back in a few minutes. So I’ll say how many and they’ll say two or three. Well I measure as best I can and 15 minutes and ½ hour and I know they say that just to make me feel good when they leave – they are not going to say half an hour and you feel neglected ‘cause they’ll say I will be right back. But I know they are coming back as soon as they can you know? I have that much faith in them. But that’s what happens – if you are in dire straits like you had badly to go to the toilet and they come back in a half an hour instead of fifteen minutes you begin to feel a bit resentful. The only time I feel pain is when they leave me in my chair too long. I’ve got a sore rear end. I am 91 years old, I can’t stand it as much as others and yet they go by their rules which say that ‘B’ has to be up two hours in the morning and two hours in the afternoon. Well I simply don’t do it – I can’t stand it. So we have some differences of opinion about that. They say those are the rules and I say but this is my rear end.

When patients perceived nurses as “just doing the job” they reported feeling like “just another patient in the bed” or “like a statistic”. When family members perceived the nurses as just doing the job they reported feeling “invisible” or not being valued by nurses.

Patients and family members who described feeling invisible were responding to their perception that some nurses were unwilling to take the time to “get to know them” or understand their situations. Patient participant 010, for example, described a situation in which she felt nurses did not respond in a supportive or helpful way to her distress calls because they lacked compassion and understanding about her disease. Another patient described observing nurses
“getting short” with patients who make demands and “using methods that you would use with children” because they only have so much time to respond to repeated calls (012). Patient participant 013 expressed the belief that nurses should try to find out more about patients. He explained:

Well I think it is very important. I think nurses should try to find out as much as they can about their patients. For example, I had a nurse, I am not going to name her or anything, who when she got me out of bed this morning, today to put me in a chair you know, she just grabbed my left arm. Well, my left arm is extremely painful and uh, I, I said please treat that arm gently. She said “well, you should tell me”. I didn’t say anymore – guess she is partly right but I didn’t know what she was doing.

When patients and family members perceived that, for whatever reasons, the nurses were ‘just doing the job’ they were much more likely to manage their relationship with the nurses by avoiding interactions.

Patients and families linked minimal levels of engagement to nurses just focusing on tasks with poorer health outcomes, which influenced their decisions about whether or not they could trust and respect nurses. The effect of minimal engagement with a family member on the health outcome of the patient and her husband, because their information needs were not being met, resulted in anxiety. Patient participant 01 described her feelings in the following transcript excerpt:

Well I think he should be included more only because I think he is looking at me going - you’re nuts! And my husband loves me but I think he’s looking at me like well are you making this out to be worse than it is? And I know he doesn’t think that but when I am not feeling well, you know, it’s like if [the nurse] could have just maybe have sat him down and said: “Its okay; it’s okay that she is crying. Crying is natural”. You know? So he’s not looking at me thinking you’re just a basket case. If somebody had maybe sat him down and said “You know, this is what’s going to happen to her. She is going to be messed up, you know...emotionally. I think maybe if they had said to him even you know, she’s 37 years old; she wasn’t ready to not have any more kids”. So even physically, or mentally, that... if he realized more that this is normal. Like this morning he said to me, “Can’t they just give you something?” You know to stop you crying. It’s ‘cause he doesn’t want me crying, you know? And I’m saying well no, they keep telling me that this is going to take a couple of weeks but its okay I am crying ... that the hormones are different, everything is going to a
different place and nothing is working like it was and I’ve lost my parts. I don’t think anyone has really ever said anything to him about any of that... like what to prepare for. They were very good at preparing time for me physically, but I don’t think they have been very good at preparing him ... where I am going to be emotionally. [if the nurses did] well I think he would be relieved. Because I think, if somebody else other than me was to say to him, you know, she’s ok ... this is a normal procedure, this is a normal thing that happens it would make him feel better...it would make me feel better.

Patients’ and family members’ decisions not to trust and respect nurses further increased the likelihood that positive health outcomes for patients and families were compromised. For example, patient participant 01 further indicated that the lack of information that she received from nurses about her care contributed to her feeling distrustful about nurses’ competence and influenced her taking action by contacting her physician for clarification about the care nurses were providing. Less favorable health outcomes resulted, in part, from the lack of information sharing between nurses, patients, and/or families that corresponded with decreased interaction. Patients and families were less inclined to ask questions.

Some nurse participants also acknowledged the negative impact of focusing on tasks on health outcomes. According to nurse participant 013, making a connection with patients and families helped to empower them, reduce their anxiety, and increase trust. She stated: “It [making connection by for example, explaining; helping them to understand] brings their anxiety level down it seems; it makes them feel included and I think it gives them some of that control back”. And,

If you don’t make that connection they seem to be more flailing about not sure who to ask questions to but uh, they definitely come right back to or they’ll wait for you if you are on break or something because they have a specific question to ask you and you seem to have made a connection. There is a level of comfort there and trust (N-013).

5.9 Section Summary

When nurses, patients and family members came together under terms of engagement that facilitated positive interaction, motivation to feel each other out during the focusing on tasks
stage of progressively engaging was enhanced. If feeling each other out resulted in positive interpersonal dynamics, it increased the likelihood that nurses, patients, and family members would progress to the getting acquainted stage of progressively engaging. As discussed in this section, factors that contributed to the development of positive interpersonal dynamics included nurses’ willingness to invest time interacting with patients and families, patients and family members initiating interaction with nurses, efforts by the group to overcome language barriers, families that were perceived as supportive and cooperative, and families that held ‘reasonable’ expectations of nurses and respected hospital routines and practices, and nurses who were cheerful.

5.10 Stage Two: Getting Acquainted

During the getting acquainted stage nurses, patients, and family members either took further tentative steps towards getting to know each other or they stepped back from pursuing more personal connections. Nurses who were willing to move forward in their relationships with patients and families were more inclined to take advantage of opportunities to initiate interactions while they were at the bedside. They were also more likely to help patients and families move to the getting acquainted stage by contributing to positive interpersonal dynamics by smiling, offering information, and showing interest in learning more about the patient and/or family member(s). While performing nursing skill competencies or other care tasks, nurses interacted with patients and family members because they recognized the importance of getting to know them. They expressed a desire to personalize their care and patients’ and family members’ experience of hospitalization. Those nurses did not regard focusing on tasks and interacting with patients and families as mutually exclusive activities. For example, nurse participant 16 stated:
When I am doing their physical wash or getting them out of bed or whatever, I am talking
to them. I am finding out about their social issues. As well as doing stuff for them or with
them I am taking time out to find out a bit about them as well. That is the interesting part
of the job to me. To find out what they used to do for a living and if they were ever married,
how long they were married. Talking to a patient today he’d looked after his wife for 18
years. She had a stroke when she was 38 years old and he looked after her for 18 years. I
let them talk about stuff like that so…but this I found out just giving him his morning wash
you know so there is a lot of interaction with that patient.

Several nurse participants expressed the belief that getting acquainted with patients and
family members was important to promoting better health outcomes. For example, nurse
participant 08 indicated that getting to know more about patients contributed to the development
of a more thorough understanding of the patient’s condition and illness context which in turn,
was useful in assessing responses and planning care. Nurse participant 08 stated:

Well to me it’s kinda a peace of mind to me when I get to talk to the family because they
tell me so much about the patients. How she was before and this is not normal for her and
this is normal for her and, “oh, she’s had a history of this and this and this”. Things you
don’t find in the charts and things that you can’t get from the patient so they are just a
wealth of knowledge.

More particularly, nurse participant 16 maintained that not knowing “what is happening out there
between the hospital and home” could slow down the healing process. By getting to know the
patient and family, she indicated that she could be more actively involved in increasing the
patients comfort while hospitalized and promote faster healing. She stated:

When they first come on the ward of course you are worried about their acute side but then,
like when I go on to night shift, I will go back to the chart, read their social history, doctor
and social work [reports]. Most of our patients are elderly now so I will find out what they
used to do during their life and what their hobbies are and maybe there is something that
they can do that they can bring in from home or whatever that makes them more
comfortable in the hospital or whatever. If you get to know some of the family members,
the ones that they trust, the ones that they want to stay here or whatever, that you could
phone late at night and say come on in or whatever, those kinds of things. And I think you
have to know what is going on at home, what is happening between hospital and home.
Like I say, sometimes it [not knowing] slows down the healing process to not know what is
going on out there (N-16).
5.10.1 Terms of engagement: Busyness.

Although nurses, patients, and families who progressed to the getting acquainted stage of engaging were well motivated toward establishing meaningful interactions with each other, their ongoing efforts to get to know each other remained time-dependent. This was because in response to changes in certain structural conditions (e.g. increased patient acuity) most nurses indicated that they were compelled to re-set their priorities. Nurses who perceived that they were unable to manage all the demands placed on them were inclined toward time allocation decisions that minimized interaction with patients and especially families – even those with whom they were getting acquainted, and refocused their efforts on completing skills and tasks associated with patient physical/medical care. Structural conditions such as high patient workloads required those working to assume responsibility for larger numbers of patients and families and/or sicker patients who required more of the nurses’ attention and reduced time. This contributed to a reduction in the amount of time nurses were able to invest in getting to know patients and families and forced them to refocus on completing nursing/medically delegated tasks. Moreover, as nurse participant 12 suggested, when nurses’ perceive that they are extremely busy even physical needs could be considered lower priority compared to medically designated needs. She stated:

So, yeah, it is a time factor. You know you are trying to do everything and you, you’ve only got so much time in a day to do it all and by the time you chart which you’ve got to do you know, give them all the required meds, you’re left with...and doing a.m. care and all that kind of care, processing orders, talking to doctors, it leaves you no time. So it is the amount of patients that you’ve got, the kind of patients that you’ve got, you know?

And,

I’ve told many of the younger ones [student nurses] that come to work on the afternoon, you know, don’t...please! If this patient is up and about and to the sink and capable of walking you mustn’t give them a bed bath because you do not have time to do that. I know you want to, we want to do all that, we want to baby them [do everything for them], we
want to take care of them but you can’t because you won’t get all your work done and you won’t get your breaks and you’ll be stressed out and you can’t do that. You know? And then what good are you? You have to let some of this other stuff that is not going to hurt them go. We have to keep them safe; we have to get them better so they can go home and if they don’t get a bed bath today that is not going to prevent that.

Nurses who looked busy were often perceived to be unwilling to engage with the patient or family members beyond their tasks. In response to verbal and non-verbal symbols of nurse busyness, patients and family members were reluctant, even afraid to initiate interactions with nurses. Indeed, when describing their observations of nurses at work, patients and family members noted that nurses always seemed to be in demand and in fact, appeared to be required to juggle multiple demands at once. Such observations led patients and family member participants to the unanimous conclusion that ‘nurses are very busy and shouldn’t be disturbed or interrupted’.

Patients and family members typically described observations that communicated busyness, for example, the rate at which nurses moved from task to task. Patient participants stated: “nurses are run off their feet” (08); “you would almost think it was a race track” because the nurses walk so quickly (07); and “I notice that nurses don’t just walk they practically run from room to room” (13). Many participants commented that they could hear call bells going off “constantly” which was a sign that nurses were busy (F-03, P-06, P-11). Participant observation confirmed that most nurses’ were ‘in and out’ of patient rooms very quickly and gave the impression that they were busy by moving from task to task; patient to patient, with little or no personal interaction with patients or family members.

Patients and family members also linked nurse busyness to structural conditions associated with the hospital environment – particularly short staffing and heavy patient loads. As patient participant 08 put it: “too many patients and not enough nurses”. Of particular note were
patients’ and family members’ observations of the effects of increased patient acuity and changing patient demographics in the acute care settings on nurses’ work - specifically the increased elderly and palliative patient population. Many patients and family members observed that the needs of sicker, more dependent elderly patients kept nurses so busy that their ability to provide care for other patients was affected. Family member participants 05 and 06 described their observations as follows:

Okay, sometimes they are not able to give the patient a bath because they just don’t have sufficient staff. Uh, palliative care will come in here so that [pause], they have had several elderly people with dementia who required a great deal of care and assistance. So the other patients are left on the back burner until they are able [to get to them]. I have found once that there, my hubby’s meds weren’t exactly on time because they have had other emergencies to tend to so they were unable to give the meds out, you know? And they have apologized for that but um, there is not enough people here to deal with all these issues.

In another example, patient participant 08 described nurse busyness as follows:

I find that the nurses themselves though are run off their feet. And I feel like I don’t want to bother them because they are so busy and they don’t stop...Just watching them and seeing them come in and out of the rooms and hearing the, the call bells going. I am just going “not again – those poor women!” And putting up with a lot of, I don’t know if I can say this, people that are in the wards that shouldn’t be here, meaning they should be in other care like, older people, I am going to come out and say it, they should be in a home not taking up time. This is a surgical ward not a ward for taking care of Alzheimer patients. But the care they need is high up there, like they need constant care and this is a surgical ward and mixing that with surgery – I don’t think it’s fair, fair for them [nurses].

5.10.2 Terms of engagement: Acuity.

Nurse participants were unanimous that it was necessary to spend more time with sicker patients and their families. The sicker the nurse perceived the patient to be, the more time was allocated to them and/or their family. Assessment of patient acuity was primarily based on diagnosis or condition and/or the stability of the patient’s condition. The more life threatening the patient’s condition (regardless of the cause of threat to life), the more acute the nurses
considered them to be, which resulted in more nursing care and time. Nurse participant 13 offered the following comment:

There are your typical post-op type things but you can have a dying patient that you have an awful lot of interaction with the family and guiding them through that process of letting go and saying good-bye to the other spectrum you could have somebody who has had a tragic accident where they are disabled for life perhaps because of that so it's endless the types of interactions that you end up getting in. You've got your line up of typical ones but you certainly get a wide spectrum. The bottom line is you prioritize.

While nurses used threat to life as one criterion for determining acuity, they also viewed patients recently diagnosed with a serious illness, such as cancer, and/or who required intensive medical treatment as more acute. Because patients were more acute, family members got more attention. The nurses indicated they were sensitive not only to the physical impact of the illness on the patient, but also to the psycho-social-emotional support and information needs of patients and especially family members to cope with acute illness and to prepare for possible end of life. Because nurses perceived that sicker patients and their family members had greater comfort and care requirements than more stable patients and their family members, they managed their relationships with sicker patients and their families by investing increased amounts of time toward getting to know them and establishing a more personal connections with them.

As nurse participant 11 explained:

Certainly if someone is more acutely ill you are going to be in there more often and you are going to spend more time discussing with them and their family members. For the most part if you've just got like a general surgical group, I probably spend about the same amount of time with each person but it depends on your clients. If they are very ill or require a lot of care you are going to be there more often and then you are going to be talking to them and interacting with them and their families more frequently.

The nurses indicated that length of hospital admission and recovery trajectories associated with certain surgeries or conditions also dictated acuity and their assessment of priority of care. They considered patients admitted for scheduled surgeries, especially those that resulted in
enhanced quality of life (e.g. knee replacement), as less acute because of low risk in terms of complications and shorter hospital stays. Nurses considered patients who were admitted for emergency surgery or treatment and/or whose surgery or treatment resulted in disability (e.g. amputation) as more acute. Although the actual diagnoses and combination of medical conditions or illnesses varied on acute medical and surgical units, nurses imposed an acuity hierarchy in acute care hospital settings on which they based time allocation. In describing factors that influenced nurses’ interactions with patients and/or families, nurse participant 14 stated:

Well, it’s actually to do with the acuity of that patient. It sorta involves my time so, the more acute they are the more time I spend with them. If they are not progressing as well then I end up spending more time with them. It doesn’t necessarily involve the family but I could be spending more time with that patient. So my other patients that could be progressing well or are less acute might not have as much time to interact with me nor would the family. Normally our fresh post-ops, regardless if they are fractures coming in through emergency or scheduled surgeries, they are more acute to me. They are fresh post-ops. They usually have multiple problems on top of, they have just had the anesthetic, they’ve had all these other things underlying so they take up more of my time in terms of acuity levels I guess.

Nurses also indicated that they considered patients who were at greater risk for experiencing deterioration in their conditions as more acute. Patients whose condition suddenly “turned sour” - that is their condition unexpectedly changed or deteriorated with more immediate threat to life, were considered by nurses as among the most acute. As nurse participant 07 described:

It’s [time] is a major factor because, depending on the needs of the whole team [all other patients], depends on how much time you can spend with any given patient. And if someone is going sour then, that’s it, its game over, you are spending all you time with that particular patient. So, it really does come down to time.

The priority given to families of acute patients varied. Generally nurses indicated that the closer the patient was to death, the more likely they were to enlarge the focus of care to include the patient and the family because they believed family members whose loved ones were dying
required more emotional support. In the case of an emergency or sudden change in patient condition, however, nurses described becoming distracted by “working on” the patient who was unstable and “forgetting there was a family in the background” (N-03). Consequently, family members may be ‘brushed aside’ (N-04, N-05). The nurses indicated that was usually temporary, until the urgent nature of the patient’s situation resolved. Following a critical incident such as a sudden deterioration in the patient’s condition or death, many nurses indicated that it was important that they made themselves available to support family members. Nurse participant N-007 offered the following example:

I dealt with a guy in his fifties or so and he was very upset about his aunt dying and he was in a very defensive posture. And um, I could tell that he was very, very strongly defensive at that point and he was about to ask me lots of questions and I took him into the hallway and I said come talk to me. And I took him into the quiet room and I just sat down with him and I just put my arm on his shoulder and the whole defensive stance that he was keeping up just kinda melted away.

5.10.3 Terms of engagement: Continuity of care.

Because getting acquainted takes time, nurses, patients, and family members indicated that ensuring consistency in nursing staff was an important structural condition that facilitated nurses’ efforts to contribute to positive interpersonal dynamics. Continuity of care meant having regular access to some nurse(s) during their hospitalization. Nurses’, patients’ and families’ efforts to get to know each other and build mutually trusting, respectful relationships were undermined by large numbers of part-time and casual nursing staff that reduced consistency in care. As patient participant 03 indicated, getting to know the nurses was easier when they were on shift more often. She stated:

Well, I think the difference happens because the nurse is perhaps on shift more. So you get to learn, know her better, you know? If they’re not on that often then you know, it’s sort of a general thing but if they’re on a lot then you really do spark up kinda a comradery or friendship (P-03).
Nurse participants also acknowledged that continuity of care was important to building trust and rapport, but this only occurred by working with patients and families over a long period of time. Nurse participant 01 explained:

I think nurses have become very task orientated. We have an agenda in the morning – I’ve got to get this all done and I think it’s the work assignments. I mean it’s nice to have an assignment where you’d have time to spend with each patient chatting about their family and their life and who they are besides this patient in a bed and you may gain that over a two-three day period of having that patient— you build up a rapport and we try to give that consistency for more than one day so that you do build up your rapport with that person and trust. If you can somehow make some consistency there I think the patients build up that trust. I mean it’s a stranger that’s looking after them basically so there has to be a big trust there.

Nurses indicated that part-time and causal nurses spent less time on the acute care unit (e.g., less frequent and possibly shorter shifts); therefore, the opportunity to get acquainted with patients and families or move toward establishing rapport with them was minimized. Moreover, the lack of continuity of care contributed to the lack of consistency in information, which also undermined efforts to establish trust. As nurse participant 03 described:

It’s definitely a building thing; it is something that you have to build up with them which is hard because we are only here for 12 hours and then there is a new nurse coming on and then there are casuals, right? So it is hard because there is no consistency and it is hard to build that relationship if you get a bunch of us telling them different things.

The predominance of casual and part-time nurses on acute care nursing units was described as an important structural condition that interfered with nurses, patients, and families getting acquainted. Through lack of exposure to and familiarity with the unit routines and the patients themselves, participants described casual and part-time nurses as more regimented in their approach to care, which influenced their willingness to engage with patients and families. As patient participant 02 and family member participant 01 observed, nurses who work on a more casual or part-time basis and/or worked the night shift were perceived to be indifferent in their
approach to care. Upon reflecting on the importance of nurse-patient interaction, patient participant 02 offered the following comment:

Well, I am sure it [interaction] is quite important for both sides. They want to have a feeling of who you are and who it is. Its, its like those girls who are on afternoons who only come once a week, they don’t really know who you are...you’re just a, just a patient in a bed.

Similarly, in her description of a positive nurse-patient/family interaction, patient participant 01 suggested that establishing a comfort level with nurses was dependent on more personal exchanges that occurred over time. She stated:

Well, because they’re so much busier and because you don’t ever see the same faces because the faces are always different, so you don’t ever get to know anybody. And by the time you are comfortable with a nurse, like I had a nurse come in for 2 evenings, who was really cool. Really liked her, she was you know, she’d come and chat and give me a hard time because she was a neat freak and I am a little bit of a got everything everywhere. Like, I really enjoyed that. But then of course that lasted for two days and then you get a new nurse. And the next nurse doesn’t say anything to you.

Such observations suggested that continuity of nursing staff combined with the frequency of interaction led to increased levels of familiarity and comfort in nurse-patient/family relationships. When nurses, patients, and family members felt ‘more comfortable’ with each other their willingness to pursue personal connections was maximized and they were more likely to move toward interaction at the stage of establishing rapport on the progressively engaging trajectory.

5.10.4 Terms of engagement: Family involvement.

Nurses also gauged their interaction with family on the basis of whether or not they were the main support person for the patient, and were perceived to be helpful in this role. According to several nurse participants, nurses are more inclined to getting to know the primary support
person in the family (e.g. the person with whom the patient co-habitates), as opposed to other members of the family. As nurse participant 06 explained:

If the family is living with them it is easier to work with them and just with different ideas that we have and different things that have worked with the patient but when they are not living with the them it is really quite difficult because there again you've got this distance and the patient is still left by themselves, you know?

When family members are a main source of support nurses are much more inclined to interact with them around care or what nurse participant 06 described as “sitting down and banging out different ideas with them” (family) especially when discharge becomes imminent. Several nurse participants, however, maintained that any family member who can help promote patient understanding and compliance is potentially an important resource. For example, nurse participant 11 explained:

Family members um, again most of the time when family members are involved it's either because the patient isn’t understanding so there is either a language barrier or maybe there's some dementia involved and so then you're teaching the family members so that if they are going to be a care provider once they go home or if they’re in hospital and they’re at the bedside frequently they can encourage all the things that normally uh, your patient would be able to do on their own. So they just assist in the patient’s improvement.

When nurses perceive family members as a resource that will be of direct benefit to the patient and/or make the nurses’ job of providing care easier they are more inclined to initiate interactions with them. More specifically, many nurse participants indicated that including family members in patient teaching was important to promote increased patient understanding and compliance, which, in turn, decreased the likelihood of readmission to hospital.

As nurses and family members interacted around patient teaching, they got further acquainted, which increased the possibility of their becoming open to pursue more personal connections and the likelihood of their interaction advancing to establishing rapport. Conversely, when nurses perceived that family members were unhelpful or were not the main support person
they were less likely to consider pursuing personal connections with them a priority. Consequently, nurses were more likely to limit interaction with those family members and they ended up falling through the cracks.

5.10.5 Terms of engagement: Friendliness.

In the process of getting acquainted, personal factors (e.g. smiling, being supportive) that conveyed friendliness, and interest in and concern for the other were increasingly meaningful in terms of contributing to positive interpersonal dynamics. When nurses, for example, were perceived as friendly and supportive patients and family members reported feeling safe, which contributed to the development of positive interpersonal dynamics. Patients and family members felt that they could trust the nurses because their warm, friendly approaches gave them the sense that the nurses' genuinely cared about them. Patient participant 05 stated:

It is so nice to be in a place where you feel safe and [pause] yeah, no put downs [pause] and encouragement. You do something, you accomplish something and you really get praised for it and, and its not phony praise. You can tell the difference if somebody is just being nice and saying ‘oh, hey, good for you’. And you think, oh, yeah right, you know? You can tell the difference. You get a feeling that you’re just not a number”.

When getting acquainted cheerful, friendly nurses were perceived by patients and family members as caring and supportive. Feeling supported and cared for resulted in positive interpersonal dynamics which facilitated trust and respect and provided the basis for moving toward building rapport in the nurse-patient/family relationship. As family participant 03 described, “You know, they [nurses] lift you up a bit. They give you a feeling that you’re not just a number”. Moreover, when nurses were perceived as genuinely concerned about the well-being of the patient and/or family patients and families reported feeling like part of the team. As patient participant 05 put it: “It wasn’t always what they said but how they said it. They had you working with them and they were helping you through a real bad situation”. Several nurse
participants concurred that providing the ‘personal touch’ - that is being friendly and taking time to consider their feelings was important to patients and families and went a long way to establishing trusting relationships with them. Nurse participant 03 explained:

I think it’s really meaningful. I think they see it as respectful that we took time to consider their feelings; to let them know we are sympathetic; just to let them know that they’re not alone and let them know that there are resources; and to explain or help them understand what is happening.

5.10.6 Terms of engagement: Positive interpersonal dynamics.

Patients and family member participants agreed that it was important for nurses to get to know patients and families. According to patient participant 13, when nurses are interested in finding out about patients, for example, their background and occupation it helps to establish a common bond. In other words, it helps the nurse to see the person as an individual person and vice versa. As patient participant 13 described:

I also think that it would be good if nurses, when they were given their instructions would be told to find out something about the people, the patients; the men – what’s their occupation? Women – do they have an occupation? If so, what kind, you know? That establishes a bond usually – knowing about occupation. And [you] get an idea of what sort of people they are because of the occupation and I think that would be good for all people to find out some of the basic things of life – which work is the basic thing in life and the kind of work you have gives you attitudes and interests and knowledge and I think that nurses probably should be told if they are not that they should try to find out something about the jobs that people had. If they could ever establish something in common the patients would be only too happy to talk to them. Once again it establishes a better bond.

Building a common bond contributes to the development of trust and respect for one another in relationship and increases the potential for the relationships between nurses, patients, and family members to move toward the highest level of progressively engaging – the establishing rapport stage.
Nurses’ motivation to engage in positive interpersonal dynamics with patients and/or family members was influenced by the meaning they associated with certain conditions/factors or terms of engagement. For example, patient acuity was identified by participants as an important contextual condition that resulted in nurses’ fast-tracking their efforts to get acquainted with patients and/or families and establishing positive interpersonal dynamics. When nurses perceived that patients were sicker or in greater need they were more likely to spend time with these patients and/or their family members around physical care tasks in combination with more personal connections. As patient acuity increased, many nurses described a heightened sense of interest and concern for the patient and/or their family members in response to their verbal and/or non-verbal signals (e.g. look anxious, crying). Those signals conveyed distress and fear to which the nurses respond by conveying concern through verbal and non-verbal expressions of support and comfort.

When nurses’ expressions of support and comfort resulted in positive interpersonal dynamics both groups entered into personal connections. When positive interpersonal dynamics occurred in the context of serious illness or potential or actual loss of life nurses, patients, and family members described managing their relationships by ‘fast-tracking’ their interactions through the getting acquainted stage and moving forward to the establishing rapport stage. Nurses also described stepping back from higher levels of engaging with less acute patients and/or family members, because they set priorities which allowed interaction with those patients and family members to fall through the cracks. Nurse participant 08 offered the following explanation:

If there is a stage where a patient is really ill then you are definitely; you know the sickest patient, you are collaborating more with them and with the family and keeping the family up to date especially if it is a palliative patient. If the patient takes a turn for the worse you call them and so forth. And then there’s the patients who are doing, they are stable. You kinda miss them. It’s just the middle group that seems to fall...the stable ones that are stable but not stable enough to go home and not too sick to be at the bedside constantly.
When patients and family members were at the stage of getting acquainted and were building on established positive interpersonal dynamics, they tended to be empathetic around their observations of nurse busyness. As a result, they described trying to “help” the nurses by avoiding or delaying interactions with them because they “did not want to bother them”. As nurse participant 08 described:

I’ve been with patients who have said “oh, I felt bad because you were so busy and I didn’t want to ring my bell”. So, that way I feel that some of them won’t share everything with you because they think you are too busy and it can wait; they’re okay so it can wait. So that is definitely a disadvantage when they see how hectic it is. They won’t say anything and some of the family members too they come and they see how busy it is and they just leave and don’t say much or come and ask.

5.10.7 Terms of engagement: Questions.

As nurses, patients, and family members progressed to the getting acquainted stage of progressively engaging nurses indicated that they were more in tune with patients’ and families’ cues indicating that they had questions or required assistance. As nurse participant 10 explained:

We’ll see them looking at us as if they have questions or they have something to talk about or you see that they’re going to ask you something but then they kinda hold back so you just have to ask them if they have any concerns.

When at the getting acquainted stage nurses became more in-tune with and could begin to anticipate patient and family needs or questions. Consequently, patients and family members did not need to work as hard to initiate interaction or engage the nurse. This was important to patients and family members because, as many indicated they experienced the hospital as a foreign and stressful environment and they don’t always know what to ask. As patient participant 01 described:

My husband doesn’t like hospitals. He doesn’t want to be here. So [it is helpful] when the nurses actually sit him down and have a conversation; ask the questions. Take the time to say okay, this is what you can be expecting for the next 3 weeks, 4 weeks.
Consequently, nurses who invested time to get acquainted with patients and family and were able to anticipate their questions were perceived by those patients and families as “good nurses” because they helped alleviate their anxiety and conveyed empathy and support. Family member participant 10 stated:

Sometimes they come up. That is good nurse. If they come up to ask me question I know that is a good nurse because they can expect the questions first. I can tell because when they come up and say that and I always say I appreciate it, you ask and I appreciate your concern.

Similarly, while describing the importance of receiving information about her mother’s progress family participant 09 stated:

I think is she is not well enough then she will have to go to a facility and that is the questions at this time. I think working closely with the girls [nurses] — the nurse that is actually on like L [whom she had gotten to know], well then, that is great. At least then you have a contact person and you know she will respond and I like having a name of someone not just kinda depending on whomever.

Several nurse participants described routinely encouraging questions and providing opportunities for patients to ask questions. Nurse participants 04 and 05, for example, indicated that they introduce themselves, call people by their names, explain their role as the nurse, and ask if there are any questions they want to ask. According to these nurses, promoting question asking signaled respect for the patient and family. By taking the time to encourage questions, nurses contributed to positive interpersonal dynamics that fostered the development of trust and respect. With this foundation nurses, patients, and family members were more likely to move from the getting acquainted stage to building rapport.

While nurses encouraged patients and family members to ask questions or ‘write down questions so they don’t forget (N-04 and 05), they also expected them to take advantage of these opportunities. When nurses are busy they indicated that they especially appreciated questions, because it helped them in their effort to respond to the specific needs of individual patients and
family members. As nurse participant 13 pointed out: “you don’t know where they are at or what they need but if they start talking or asking questions you really know what information to give”.

During getting acquainted, if patients and/or family members did not ask questions, nurses were still inclined to assume that “everything was okay” and moved on to the next patient – particularly if the nurses perceived that they were busy. Thus, not asking questions may limit opportunities for nurses, patients, and family members to move through getting acquainted to building rapport. Consequently, several patients and family members indicated that they came to understand the importance of participating more actively and to assume greater responsibility for their or their loved one’s care by engaging with nurses through question asking. This not only allowed them to get acquainted with nurses but to move to building rapport with them. Family participant 06 for example, stated:

If you have a question, if you query anything, ask the nurses and they will tell you. They will tell you; they are so helpful...That is my experience. I have asked many questions. I have asked about meds...different questions and they have helped me. What else can you expect from them right? Don’t be afraid, you know? People might think ‘oh she is a professional nurse; you must not interfere. No, do interfere – they don’t mind! You should do it whether you are afraid or not ‘cause they won’t bite you. You have to do it in this day and age [referring to nurse busyness].

Similarly, patient participant 13 indicated that: “The patient has to let them [nurses] know. It isn’t fair to think unkindly of them if you don’t let them know what you need. The patient has a responsibility and the nurse has a responsibility.

With more opportunities to interact around questions, nurses, patients, and families became better acquainted. Moreover, the better they got to know each other the better nurses became at anticipating patients’ and family members’ questions and/or needs. This resulted in positive interpersonal dynamics that offered opportunities for personal connection in the nurse-
patient/family relationship. In turn, nurses reported that patients and families appeared less anxious and seemed to trust nurses more. As nurse participant 10 described:

I think sometimes they feel the stress but are able to be more relaxed. They are more willing to help you and [families] are more willing to help the patient. I think because they are more able to trust you; they trust what you are doing- that you are doing the right thing for the patient. You are helping the patient.

Many nurses described their ability to anticipate questions and interpret cues as an intuitive sense that developed as they got to know the patient and/or family. As nurse participant 07 explained: “I think it is just an intuition; it's a sense that somebody needs better communication, better information, more information; that a particular person needs more TLC or comfort. I think that you just have a sense”. Nurse participant 11 emphasized that time was important to developing an intuitive sense about patients’ and families’ questions and needs. She stated:

The more you work with people, the more you pick up on little things. You just sorta know if there is something untoward; that there is a problem that has to be addressed and you go and talk to them and you might be wrong, they might be upset about something else but, you know?

As nurses, patients and family members progressed to a more intuitive level of managing their relationships, they were more likely to move into the third and final stage of progressively engaging - building rapport.

5.10.8 Terms of engagement: Personal sharing.

As nurses became more intuitive about the needs and concerns of patients and families, trust and respect in the nurses-patient/family relationship grew and positive interpersonal dynamics incorporated more social interactions. As nurses, patients, and family members got acquainted they were more willing to invest time in interacting on a social level. According to
participants, social interactions were characterized by 'chatting', joking, and acknowledging each other (e.g. by name and/or with a simple wave). Family participant 08 offered the following example:

Well, there was this one nurse that had looked after H [husband] last week for, I don’t know how many days, but she just noticed me in the room today and she waved and said ‘Oh, hello Mrs. B.’ – by name and everything you know? Other ones [nurses] its ‘well, she’s here’ and that’s it and they walk on.

Social interactions focused on social ‘chatting’, which participants indicated were more casual conversations about topics unrelated to the patient’s illness or hospitalization or what patient participant 08 referred to as “not all doom and gloom”. She stated:

Any questions are answered quickly that you have concerning what you should or shouldn’t be doing and uh, [they] just take a minute to reassure you that everything is going to be okay. And it’s quite nice because it’s all not gloom and doom. It’s um, nice that they can talk to you about pleasant things too. You know? Rather than talking about being in a hospital bed [they talk] about flowers or anything, gardening which makes it [interaction] a lot nicer.

Because social interactions were less technically focused participants regarded them as friendlier and more personal in nature. Nurses, patients, and family members regarded initiating or participating in social chatting in acute care hospital settings as an indication of the desire to pursue a more personal connection.

Interacting on a more social level offered opportunities for nurses, patients, and family members to become increasingly familiar or acquainted and comfortable with each other. With increased familiarity, trust and respect for each other flourished. Their mutual trust and respect increased their willingness to exchange more personal details and enhanced their personal connection or bond. As patient participant 05 described:

You get to know a little bit about each other on a personal side. I know one nurse has a real nice dog; I know another nurse has 3 grandchildren; I know that another nurse has a cottage at Cultus Lake, you know, these kinds of things that are totally unrelated to [pause] but it’s not that we, we never sit down and talk for hours about these things because, after
all they are at work. And I’ve got things to do too. If it isn’t physio I have to go eat again so I can gain some more weight you know? So, but it’s the little things that come out in passing conversation when they are in like making beds or moving another patient or, whatever, you know? Yeah, the relationship actually grows. It doesn’t deteriorate as you get better, it grows.

Nurses, but more so patients and family members, perceived social chatting as extremely important. Patients –especially those who were hospitalized for long periods appreciated more social interaction with nurses because it kept them connected with what was happening in the world. They indicated it kept their spirits up and contributed to them feeling like they were valued as a person. Family members reported that social chatting was a way that nurses acknowledged them, which in turn made them feel more welcome and increased their motivation to become more involved in the care and support of their ill family member. Patient participant 04 and her daughter, family member participant 02 offered their perspective on the importance of social chatting with nurses:

F-02: Sometimes when you are here for six weeks they get to know you a bit and so they are more willing to chat and let you know how things are going. F-02: Oh just even see how the day is going and friendly everyday type conversation not necessarily revolving around the clinical condition. P-04: I think that’s pretty important because for one thing when you’re here for an extended period and when you don’t have visitors in all day it’s nice to have that. I know it’s nice to hear what is going on in the outside world. F-02: I think it is pretty important because our family is such that we really try to keep on top of what is going on and so any information that we can get from the nursing staff is helpful because we are not always here to see the doctors when they are here. It means that when I get to go home at the end of the day and make all the long-distance phone calls I can tell people what is going on and I can phone my aunt who is a nurse and say ‘this is the way…’ and she understands and can sometimes think of questions that we wouldn’t think of not being in the medical profession - a feeling of security. It lets me know that something is happening because sometimes we feel like nothing is happening because we can’t get answers.

As a benefit of increased familiarity, trust, and respect gained through social interactions, nurses, patients and family members managed their relationships with each other in a more
collaborative manner. They were more likely to move into spontaneous sharing of information, which was characteristic of the third stage of progressively engaging - establishing rapport.

5.10.9 Terms of engagement: Cooperative/compliant patients and families.

Patient participants indicated that the sense of trust and the feeling of being cared for that began to develop while getting acquainted enhanced the patient’s respect for the nurses. This, in turn, had a direct impact on establishing positive interpersonal dynamics, within the nurse-patient/family relationship. As well, nurses, patients, and family members agreed that the competence with which nurses were perceived to perform nursing care functions was the bedrock on which patient and/or family trust was based.

Patients and family members who trusted the nurses were more likely to comply and/or cooperate with nursing care. In turn, the nurses interpreted compliance and cooperation to mean that the patient and/or family respected and trusted them. Moreover, compliant, cooperative patients and family members were considered ‘good’ because they made the nurses’ job easier. This reciprocal appreciation contributed to positive interpersonal dynamics that facilitated nurses’, patients’ and family members’ willingness to establish more personal connections by getting better acquainted and provided the foundation for moving into the establishing rapport stage of progressively engaging.

5.10.10 Terms of engagement: Negative interpersonal dynamics and stepping back.

During stage two, when nurses, patients and families were getting acquainted they continued building on a positive interpersonal dynamic that began during the focusing on task stage. This positive trajectory, however, could be disrupted by responses to negative terms of engagement that in turn, contributed to negative interpersonal dynamics. For example, patients’ and family members’ responses to nurse busyness, such as not wanting to bother nurses, were the result of
their good intentions and reflected a positive regard for the nurse(s). Unfortunately, they also inadvertently contributed to preventing nurse – patient/family engagement from moving beyond the getting acquainted stage of progressively engaging as a result of lack of interaction.

In another example, when nurses believed that time constrained their abilities to attend to more than the priority basic physical/medical care needs of patients and families with whom they shared a personal connection and were becoming familiar, many described feeling frustrated and stressed in their work. Some nurses indicated that they let patients and family members down when they were forced to step back from some patients and/or families in order to allocate more time to sicker/needier patients and families. As nurse participant 08 described:

I understand that from the family and the patient’s point of view that they expect the best for their loved ones and the patients expect the best for themselves but it’s just not realistic in this environment that I work in. We definitely do our best but we just can’t be there doing one to one nursing so they, they think that ‘oh, I am being neglected, they don’t care’. They see it that way. At the same time we are frustrated because we don’t have enough time to spend with the patient.

In some cases, nurses felt that the need to step back from patients and/or families after having established positive interpersonal dynamics was not always under their control. When nurses were busy, for example, they described often having to put patient care first and ‘fit families in only if time allowed’. Several nurses also described having to privilege patients and reluctantly stepping back from engaging with families when there was disagreement about what was in the best interest of the patient. As nurse participant 01 explained:

I mean you can only do so much and patient safety comes first. If that patient needs that care, you may step on some toes to get it and if that’s the family I mean you have to step away and say, ok, the patient comes first and patient care comes first and if that doesn’t fit into what the family wants well, we have to do this because that’s where this patient has to go. So I think there is frustration but I also think if you, I always say that if you keep what’s best for the patient in mind that’s where you go. And in fact, if that means upsetting families then sometimes you may have to do that but I think that you can still explain to them.
Disagreements around care could also result in patients and/or family members stepping back from nurses because the patient and/or family member(s) felt intimidated, misunderstood, or judged by the nurse. As nurse participant 02 described:

The patient or the family that don’t want interaction with the nurses or have the nurses be involved, that is pretty obvious most of the time. Although having said that, sometimes when you talk to them a little bit there...initially they might be defensive and sometimes when you talk to them a little bit and they realize that you are not there to make a decision you are there to try and help them make a decision, understand more so they can make a more informed decision, sometimes they back down. I would say there are few families who say No! There are some who are absolutely definite about the way it’s going to be. Like one lady, her Mom was 92 and she was to be tube fed and the lady had pulled the tube out twice. And her daughter wanted this tube back no matter what. And she was not interested in hearing from her mother’s perspective or from our perspective – she wanted it done.

When positive interpersonal dynamics between nurses, patients, and families during stage two were disrupted by family members whom nurses perceived as demanding and/or uncooperative nurses indicated that they were more inclined to step back or even opt out of personal connections with those family member(s) in favor of preserving positive interpersonal relationships with the patient. However, as nurse participant 13 pointed out, negative nurse-family interpersonal dynamics could also cause the patient and/or the nurse to step back from previously established personal connections with each other. As nurse participant 13 explained:

Where you have a connection with the patient and you are moving along quite well with that patient and progressing and then a family member comes in and due to whatever the dynamics are or the personality of that particular person - all of a sudden the barriers go up again. Then that’s where you are challenged with winning over not only the patient but this new member who has shown up at the bedside now because they will directly influence how you are moving along with the patient.

As several participants suggested, getting acquainted took time and effort on the part of patients, family members, and particularly nurses. Often, even though nurses, patients, and family members were willing or open to sharing personal details that helped build more personal connections, nurses were willing to invest time to provide information, support and comfort, and
patients and family members were willing to engage nurses by asking questions, their efforts were constrained or thwarted completely depending on various structural conditions affecting their relationships. For example, as patient participant 06 suggested when, in response to such negative terms of engagement as short staffing, many casual staff nurses, and high patient acuity, nurses did not take the time or were not able to take the time to chat socially with patients the hospital experience was more negative, because patients felt like just another patient in the bed. Patient participant 06 stated:

I think it [more personal interaction] would be very important because other times I have been in there, I can’t say I enjoyed myself but you could have a conversation for 5 or 10 minutes. They’d take, they’d talk to you and you would talk about their kids; their family or tell them about that damn husband of mine, you know, just joking but...treat you more as a person rather than just a patient. You’ve got feelings and family and things to connect with.

5.11 Section Summary

When nurses, patients, and family members shared positive interpersonal dynamics they described motivation to get to know each other and to pursue more personal connections. They moved into the getting acquainted stage of progressively engaging. As discussed in this section, factors that facilitated positive interpersonal dynamics included patient and family members’ willingness to ask questions and nurses becoming more intuitive about patient/family information and other needs. The group also became more willing to share more personal information and engage in social chatting. Getting acquainted was enhanced when family members continued to be perceived by nurses as cooperative and supportive and when nurses continued to be regarded by patients and family members as having a friendly, cheerful approach. All participants indicated that getting acquainted was also easier when patients and families had more consistent access to the same nurse(s). Positive interpersonal dynamics could be ‘fast-tracked’ by nurses who perceived patients and their families as more acute. In other
178

words, they created terms of engagement which moved them quickly into getting acquainted. Conversely, nurses stepped back from higher levels of engaging with patients and their families who they perceived as less acute – even if they had begun to get to know them. When nurses set those terms of engagement the likelihood that those patients and family members would fall through the cracks was increased. When positive interpersonal dynamics occurred at the getting acquainted stage there was enhanced the mutual trust and respect in the nurse-patient/family relationship which increased the likelihood that they would move to the third and highest stage of progressively engaging - establishing rapport.

5.12 Stage Three: Establishing Rapport

In the final stage of progressively engaging, establishing rapport, nurses, patients, and family members managed their relationships by developing high levels of trust and reciprocity. Reciprocity reflected a willingness among nurses, patients, and family members to exchange gestures of recognition, to give each other support, and to give the benefit of the doubt when interactions were disrupted or delayed, or conditions and factors shifted to influence interactions negatively. Exchanging gestures of recognition and support were described by participants as “adding the personal touch” or “going the extra mile”. Like other stages of progressively engaging, establishing rapport was influenced by the negative or positive interpersonal dynamics occurring within nurse-patient and/or family member relationships. When individual responses to conditions and personal factors resulted in positive interpersonal dynamics, which were characterized by a deeper exchange of personal information, nurses, patients, and family members were more willing to continue to establish higher levels of rapport and to pursue positive interpersonal dynamics.
5.12.1 Respect, trust, and reciprocity.

Several nurse participants indicated that their decisions to move to the establishing rapport stage of progressively engaging depended on their perceptions of their treatment by patients and families. When patients and families were more tolerant of nurses’ other activities and responsibilities, more willing to help themselves or their ill family members when appropriate, respectful and cooperative with nurses, more willing to follow hospital policies and routines, and more likely to have expectations that nurses regarded as reasonable nurses were more likely to categorize them as respectful and trustworthy and indicated a willingness to “work with them” or collaborate. Nurse participant 07 explained:

The nurse that is treated respectfully and politely will want, I think will feel like she can work more with the family and want to work more with the family than with people who are hostile and demanding and who have overly high, unrealistic expectations of what being in hospital means...because it is a human interaction and we respond more positively to people who are nice to us.

When nurses felt respected, trusted, and supported by patients and families they spontaneously provided information to patients and families, bent the rules, spent time chatting, or provided ‘extra’ (beyond that which is required) care or what nurse participant 04 and 05 referred to as “the little things” that nurses do. Nurse participant 04 and 05 stated:

N-04: He’s [patient example] not just a patient and I think the best thing that I did for him was that I washed his hair. And the family didn’t know a thing about ventilators and so all they say was that his hair had been washed. So it is the small things that mean a lot to the family; little things really help between the nurse and the family and patient. The service that was done for them. N-05: It humanizes everything right? N-04: Some patients make nursing easier and make communication easier. And some patients are more forthcoming than others and so the selection might just be that one gave the nurse a box of chocolates (laughs). N-05: We’re people and they’ll go “oh my god you must be tired”, they’ll say. And we’ll say oh, I don’t care I’ll go for that ice water, you know? Because they acknowledge you as a human being.

When patients and family members felt respected and recognized as people (positive interpersonal dynamics) they engaged in behaviors that were regarded as facilitating more
positive interpersonal dynamics which put them in a cycle of establishing rapport. Some nurse participants acknowledged that respect and trust within nurses’, patients’, and family members’ relationships were not only aspects that developed over time but were also elements that had to be earned. In other words, nurses, patients, and family members who reached the establishing rapport stage of progressively engaging were more likely to understand that showing respect and trust for each other yielded trust and respect in return. Nurse participant N-005 stated:

I think if you show respect for the family – don’t treat them like kids, like all this dear and sweetheart, just throwing that out. Talk to them at their level. If you show them respect you get it back. If you treat them like “oh well, you won’t know what I am talking about” you know, then things shut down.

5.12.2 Interpersonal dynamics.

At the stage of establishing rapport, structural conditions, such as time, had less bearing on nurse-patient/family relationships. According to several patient and family member participants, they were more likely to develop more personal connections with nurses who were encouraging and supportive of patients’ efforts and progress. While these personal connections developed over time, during the establishing rapport stage, they transcended time. In other words, nurses, patients, and family members in the establishing rapport stage shared a comfortable, positive regard for each other that could withstand less frequent interactions; emphasis was placed on the personal quality of the interaction, as opposed to the frequency of interaction. As patient participant 05 described:

Because you are here for a long time, months as you know, when you first come in, no matter what your problem is, you’ve come in a bad way. You’ve got big problems so the staff do get to know you and you almost, well you don’t really become friends because it doesn’t get that close but there’s uh, there is to a certain extent a friendship. I’ve been here a long time now and especially last week I have done so well that I haven’t needed as much from the staff. But they come into our room and always talk to you and if I am already dressed they’ll say “oh, aren’t you a smarty pants today” and give me a pat on the back.
At this stage of the process, patients and family members tended to be more tolerant of nurses’ absences, because interpersonal dynamics had been positive and patients and families had developed trust and respect for nurses over time. They were willing to give the nurses the benefit of the doubt when interactions between them were delayed, disrupted, or resumed a more business-like quality. As patient participant 03 explained “they [nurses] can’t be everything to everyone”. Similarly, family participant 03 commented that: “they [nurses] are doing the best they can”. When patients and families were willing to give nurses the benefit of the doubt occasional negative interpersonal dynamics were more likely to be considered (albeit temporarily) a practical and necessary approach by nurses to cope with multiple demands on their time.

Tolerance was conveyed when patients and family members ‘tried not to bother the nurses’. This was done by avoiding using the call bell, attempting to be patient, trying to help themselves or their family member as much as they could, avoiding asking questions unless it was absolutely necessary or seeking answers from other people e.g. “going to the desk”, and trying not to bother nurses during busier times on the unit such as at change of shift. Patients and families were more likely to give the benefit of the doubt to and be tolerant of nurses whom they trusted and/or respected and who were perceived to be busy attending to sicker/needer patients. Patient participant 13 stated:

I just feel the nurses feel they have to go there [to other patients] and I will just have to wait. Because waiting doesn’t kill you, you could be as uncomfortable as hell you know, and painful but somebody else might be in a much more serious position. So that’s why I don’t want to blame them. I don’t want to think that they are neglecting me because they don’t come when I want them to. I know they’ll come as soon as they can.

Patient and family members showed reciprocity by being cooperative with the nurses and by being forgiving of the discomfort or inconveniences they experienced while waiting for the
nurses to respond to them. Several patients stated that they would refrain from ringing the call bell unless it was absolutely necessary. This often meant that they sometimes had to endure some degree of discomfort until the nurses could get to them. The effect of patients' perceptions of tolerance for nurses is explained by patient participant 13 who stated:

[When nurses are busy] often I don’t bother them when I should. For example, they’ll put me in the chair you know, because I am supposed to spend a certain amount of time in a chair but I have a rear end that is very sore – I can’t stand much. And I’ll be kept much longer than I should from my stand point but I try to understand and uh, I don’t raise hell about when they don’t come when I think they should. I try to be understanding and look at it from their standpoint.

Family participants were also more tolerant of nurses when they felt they had established a personal bond with the nurse. Family participants 05 and 06 offered their views:

F-05: Oh, I feel very comfortable [with the nurses]. [Because of] their mannerism, the times that you did need their help they, they were there to help. F-06: They are very comfortable with you. They are on a personal level. F-05: A personal level yeah, personal level. F-06: They smile, their smile. F-05: [and that make me feel like] yeah, oh my goodness she’s with me, she’s okay, you know, she’s one of me. F-06: She [the nurse] wants to help out, care, she want to make sure that we understand. F-05: They [nurses] are very honest mind you, very honest...If they are behind schedule and I ask for something they may say yes, but not right now because I haven’t got time. I say fine.

Other patient participants indicated that they would do as much for themselves as possible in an effort to help the nurses. Patient participant 04 stated: “I feel that I try to do as much for myself as I can. I’m not one to want to sit back and just...be done for. And I think that it helps the nurses when they are not pushed by every one of their patients, to be doing everything for all of them”. She went on to discuss the importance of having family members present who could help with her care so as not to take up the nurses’ time. Patients and family members also tried to avoid asking questions unless it was urgent.

Nurses also observed that trusted patients and family members were more reluctant to bother nurses when they were busy. Nurses, patients, and family members at the stage of establishing
rapport were more inclined to communicate with patients and families about structural conditions and personal factors influencing nurses’ work; apologize for delays; keep promises; and offer explanations about what to expect. For example, nurse participant 08 explained:

But it’s just going in there and being open with them, you know? I understand you are concerned and this is what we are doing. What I find helpful is if you tell them when you go in there “oh, this is what we are doing for your Mom today and this and the doctor has come in to see him or her and um…” I usually tell them that there is 8 of them and 1 of me so you have to be patient…[once you do that] they definitely back down a little bit; they kinda understand. And some of them they see it. They see us running around and become much more understanding.

A hallmark of the establishing rapport stage was nurses’, patients’, and family members’ relationships characterized by a mutual willingness to spontaneously share information. At this stage nurses, patients, and family members did not have to rely on questioning to exchange information and spontaneous sharing of information was perceived as signal of utmost respect for and caring about the well-being of the other. As nurse participant 14 maintained, keeping patients and families informed was not only a sign that the nurse respected them, but it also increased the likelihood that patients and families would trust and respect the nurse in return. When nurse-patient and/or family relationships were characterized by reciprocal trust and respect they were more inclined to work together as a team.

Nurses in the establishing rapport stage recognized that patients and family members had valuable information and insights about their condition and progress. These nurses also recognized that working together with the patient and family; by listening and sharing information permitted problems and concerns to be detected and acted upon more quickly. This perspective was expressed by nurse participant 02 when she stated:

But a lot of the time families ask you. Sometimes it’s a non-verbal way you identify. They look very confused or they can be very distraught. And when you talk to them a little bit more some of the concerns do start to come out. Sometimes you just have to listen to what they have to say and sometimes to tell them that these feelings that they are going through
are not abnormal, but a lot of patients go through these same feelings or the families go through the same feelings. And sometimes to, they need to hear that they are not a bad person because they have decided that the Dad should be a no code, you know? Sometimes it's just that you have to explain the code – what happens in a code and then they realize, no, I don't want that but then there is all the guilt feelings, they feel bad because they have given up. Basically talking to them, building a relationship with them - then they'll come to you quite often.

Patients and families also described benefiting from decreased stress and anxiety and increased trust in the nurse when they had a better understanding of the nursing care and other care being provided. Nurse participant 14 explained:

I think it (information) is very important...so that they are more informed. They have more knowledge. They have a better understanding of what is going on with the patient and things to look for, what to expect, you know? I let them know what I am doing to facilitate getting them better. I think it makes it better in terms of we have a better rapport with one another um, nobody is left in the dark. Everybody is open in communication. Levels are constant between me and the patient or me and the family member and the family is well aware of what is going on with the patient and the level of care being provided. [And] hopefully they think I am doing a good enough job [laughs] but you know, I am still providing care although I am letting them assist in the care as well but they also feel that they are part of the care and they know what is going on as well. [And being able to trust the nurse is important to families]. They are placing their family members and their level of care and everything into my hands so, I think they need to have a sense of trust for us. They can see us and I think if we can establish some sort of a communication or rapport with one another that you know, there is a level of trust established along with it.

As several participants reported, when nurses, patients, and family members reached the establishing rapport stage of progressively engaging continuous positive interpersonal dynamics facilitated a “willingness to work together as a team’ (N-06). Patients reported being more inclined to engage and work with nurses who made them feel like a human being as opposed to just a statistic. Family members were more inclined to work with nurses who made them feel more welcome in the hospital and valued in their roles as support persons for the patient and as a resource for information.

Working together as a team allowed an increased willingness to spontaneously share information in a way that was perceived by participants as going above and beyond with each
other. Those activities enhanced mutual trust and respect. Nurses, in particular, were more inclined to go the extra mile in their work. Going the extra mile, or above and beyond, was demonstrated through simple acts, such as providing an information pamphlet (spontaneous sharing of information), bringing a cell phone to the patient so they call family, or filling a water jug when they are ‘busy’ (doing extra tasks), allowing visitors to stay a little longer than normally allowed (bending the rules).

According to family member participants 05 and 06, when nurses spontaneously shared information with patients and family members, especially when this was done with a friendly smile, it was a signal that the nurse was willing to engage with them on a more “personal level”. This made patients and families feel more confident in the nurse, more “comfortable” approaching the nurse (e.g. with questions), and more ‘cared for’, or as family member participant 05 put it “you feel at home”. Thus, going the extra mile really came down to nurses’ willingness to engage in a “deep human experience” (P-03), which was conveyed through acts of genuine caring. This perspective is captured in the following description offered by nurse participant 07 who stated:

I think the need for a very calm and obviously, concerned, very interested in the fact that I want to help them. Conveying to the family and the patient that I actually care about what I am doing here. I think with what you say, how you say it, the approach that you say it with - it might be just the words that you choose to use. And again I think touch is really important. As soon as you touch someone the, the nonverbal communication is so much stronger than the words.

Family participant 10 also noted that she was more inclined to trust “good nurses”. Good nurses were those who cared enough to know that she was worried and did what they could to provide information. She stated:

When I find a good nurse, if they don’t have the answer they go and look for it for you. Yeah, the good one does. They know that you’re worried, you’re concerned you know?
[example] why she [patient] is pain? This morning she vomited why is that? And important questions that concerns the family right?

Several nurses reported that, by establishing rapport with a patient and/or family, they felt more ‘in tune’ with patients’ and families’ information needs and could anticipate their questions better. As nurse participant 11 pointed out:

Whether or not they are verbal or just the way that they look or the way that they do things or they are not willing to do things or whatever. Certainly if I see somebody who seems to be needing some encouragement to get on with mobility or whatever or they seem to be depressed or something, I would go and talk to them and try to find out what is going on. The more you work with people the more you pick up on little things you know? You just sorta know if there is something that is untoward and you think yeah, there’s a problem that has to be addressed and you go and talk to them and you might be wrong, they might be upset about something else.

Several nurses also stated that they believed anticipating patient and family information needs was important to patients and families and contributed to positive interpersonal dynamics that facilitated establishing rapport. Nurse participant 02 stated:

I can put myself in their place and think ‘gee, to see someone who shows enough interest to ask me a question as a family member, well, they must be more caring’. They are reassured that you are there for their loved one.

Although establishing rapport was less likely to be negatively influenced by time constraints and high patient case loads, getting to know each other and developing trust (a necessary precursor to establishing rapport) occurred over time, therefore, for nurse, patient, and family member participants to reach that stage of progressively engaging was highly dependent on continuity of nursing care. As nurse participant 11 explained, the more patients and family members get to know the nurse, the more comfortable they feel. The more comfortable they feel, the more open they become to initiating interactions with nurses (e.g. asking questions, sharing information) that facilitate positive interpersonal dynamics.
I think your availability to your patients definitely is important. And your rapport with them; they are going to feel more comfortable to come and talk to you if you’ve got a good rapport with them and if you are there. If you are bopping in and around and they see you frequently then they are more apt to remember what they, you know, I mean you don’t always remember at the given time when the nurse is right there and if she is only there once or twice well, you might not remember all the questions that you have. I mean we are usually pretty available; we’re here for 12 hour shifts most of us so you’re going to see us frequently throughout the day (N-011).

5.12.3 Stepping back.

When the frequency of nurse and patient and/or family interactions was limited by casual and part-time nursing staff or lack of time (so that nurses are less available) rapport building will be minimized or will cease altogether. Nurses, patients, and family members who had progressed to the establishing rapport stage, but were challenged in their efforts to maintain contact with each other, found maintaining positive interpersonal dynamics more difficult. Lack of nursing continuity presented a barrier to pursuing more personal connections and caused patients and family members to step back from their relationships with nurses. Moreover, as several nurses indicated, decreased continuity of nursing care affected patient outcomes. In those situations, patients and families were less trusting of nurses who were unknown quantities and were less inclined to be cooperative or willing to share information. Moreover, in those situations, lack of time or increased patient workloads, were more likely to result in negative interpersonal dynamics which disrupted the process. As nurse participant 13 explained:

If they [patients] are still very untrusting or its somebody different or somebody new [a nurse with whom they haven’t established rapport] you really see that reflected in how they do that first time, that is the first time rolling over in bed or the first time sitting up in bed, its that first time that is always the issue – not only of trust but of anxiety. It’s the unknown; how is it going to feel, is it going to all fall apart on me? And they are really depending on somebody that they can trust to say yeah, it’s going to be okay. It’s going to hurt but you’re going to get through it and it’ll all work out.
As a result of decreased continuity of care, progress in the patient's care or treatment that had been gained could be diminished because patients and family members opted out of interactions with a nurse they did not know.

5.12.4 Doing the job with heart as outcome.

When nurses, patients, and family members brought themselves fully to interactions the positive interpersonal dynamics facilitated nurses' willingness to go the extra mile and convey that they really cared about what they were doing with patient and families. They also influenced patients' and families' willingness to go the extra mile and support nurses in their efforts to provide care, given the constraints of the acute care environment. All participants were willing to pursue personal connections at the highest stage of the progressively engaging process - establishing rapport. Establishing rapport was characterized by trust, respect, and reciprocity. The outcome of attaining this stage of progressively engaging is referred to as 'doing the job with heart'.

While the outcome 'doing the job with heart' was difficult for participants to articulate it was most aptly described by one patient participant as "a deep human experience" as she reflected on the difference between what she anticipated hospitalization to be like and what her actual experience was. Patient participant 03 stated:

Well, just the fact that the nurses are really made of people who are just doing their job like everybody else, you know, in a sterile environment that is basically, unemotional and unfeeling and it is not like that at all. It really is a deep human experience.

Other patients and family members talked about expressions of love and feeling cared for. Most nurses, patients, and family members, described it as 'treating others or being treated like a human being and not just another patient in the bed or just a handmaiden. For example, nurse participant N-017 stated:
You still maintain that professionalism, nurse-patient professionalism, but also you slip in the personal aspect as well, you know, you don’t treat them as a patient in that bed, you always do but you get a little under the covers – [laughs] that’s not really a nice thing to say for your report but you know, you get the nurse may get more attached to that patient on some surface.

Patient participant 04 also described connecting with nurses on a personal level. She stated:

They [nurses] share in emotions and we have talked about different things. One of the nurses that I had on the ward she heard that I was coming in and she came up to find out what I was doing on the ward and assured me that she was going off duty right then but would be back for the next couple of nights and would be my nurse coming in. So, that was a really nice feeling, I mean she didn’t have to do that. She could have just appeared for work the next day but she’s just a really nice young gal that went out of her way to do the extra that wasn’t necessary. And um, some of the others have done little things like that but that was especially... made me feel comfortable and at home and ok. This is ok because I was really upset to be back in. It’s been only three months and I thought I can’t be going through this all over again!

Based on her experience being at the bedside for several days supporting her ill mother family participant 10 asked to make the following recommendation. She stated:

I want [to make] a suggestion. In future maybe you have to train the nurse ask them to dedicate the heart. It is very important. Loving care, that is extra, extra I know. If you don’t have the heart and loving care you should not be a nurse. That is what I find myself. But to be a nurse, you know what, when a good nurse comes I really respect them. I think oh you are just a great person because you are not even doing your job; that is not your mother but you just care for her like a mother and I just think they are great, I just think they are great, I really respect them.

Most participants likened ‘doing the job with heart’ with experiencing enhanced feelings of trust and security about each other in relationship - feelings that were consistent with being fully engaged in relationship. Moreover, trust, respect, and reciprocity were consistently linked to creating a more positive, supportive environment for patients and family members that in turn enhanced health outcomes - what patient participant 10 referred to as helping patient’s cope with “difficult situations”.

When nurses, patients, and family members were in the stage of establishing rapport the outcome was an enhanced sense of well-being among patients and family members which they
all believed enhanced healing. Nurse, patient, and family participants concurred that establishing rapport by showing respect and sharing information was important to patients' overall healing/recovery process, because patients and family members were more inclined to cooperate with nurses, comply with treatment/care recommendations, feel good about themselves and feel hope. Nurse participant 13 offered the following example:

It [feeling reassured; 'comfortable in the relationship'] goes to the level of following through on suggestions that you make for their care or uh, their mobility. They are very anxious about that first time to start moving or to start getting up or whatever um, but if that one particular nurse, if they really trust and you are there saying it's okay you can get through it, it's amazing how much better they'll do.

Nurses reported a greater sense of personal and professional fulfillment when they perceived that patients and family members trusted them; and particularly when they regarded health outcomes as favorable. Doing the job with heart was clearly seen by all participant groups as promoting patient/family well-being and positive regard for nurses and the health care system at large. Nurses perceived their relationships with patients and family members positively and felt more fulfilled and satisfied in their work. This was because nurses described being able to observe the benefits patients and families experienced from establishing rapport with nurses, but nurses also benefited by feeling more satisfied in their work with patients and families. Nurses gained a sense of accomplishment and pride in a job well done. As nurse participant 10 explained:

I think it makes your nursing care more satisfying because you can see the family relax and they cooperate, and they sometimes give you some information about the patient. They might say, "you know my mom has been having chest pain on and off for a long time" especially if it is your first day and you don't know the patient and they say this is some ongoing process that she is having chest pain and that helps in your nursing care, sometimes it's a teamwork with the patient and with the family.
5.13 Chapter Summary

In this chapter, a description of the participant sample including demographic characteristics for the nurse, patient, and family member participant groups was provided. A presentation of the substantive theory of progressively engaging followed. Progressively engaging describes how nurses, patients and family members managed their relationships during acute care hospitalization. Following a brief overview of the theory, the three stages of the process of progressively engaging (focusing on tasks, getting acquainted and establishing rapport) and the positive and negative interpersonal dynamics that influenced movement through the stages or resulting in falling through the cracks, stepping back, and opting out were discussed. As will be discussed in the next chapter, interpersonal dynamics which resulted in failure to progress beyond the focusing on tasks stage or resulted in stepping back from personal connections at higher stages of progressively engaging suggest several implications for nursing education and practice, as well as the need for further research. The next chapter also provides a discussion of the theory of progressively engaging in the context of the literature.
CHAPTER SIX

6 Discussion and Implications of the Study Findings

In this chapter, I discuss the study findings in the context of the literature associated with family nursing theory development and practice. The chapter also includes the nursing practice, education, administration, and research implications. I begin with a summary of the substantive theory of progressively engaging, followed by a discussion of progressively engaging as a substantive theory which could potentially guide nursing practice in medical and surgical acute care settings. Next, I compare and contrast key aspects of the progressively engaging substantive theory with the literature. I will discuss how my theory refutes, supports, or extends existing empirical work in the substantive area of family nursing. This discussion will be organized around the three themes that represent primary challenges to implementation of family nursing theory to practice. The three themes are: conceptualizations of family, the inadequate explanation of contextual conditions and factors in acute care hospital settings, and the lack of empirical evidence about interactive processes between nurses, patients, and families. Finally, I discuss the implications of the theory for nursing practice, education, and administrative policy development in acute care hospital settings, as well as discuss areas for further research.

6.1 Progressively Engaging: A Summary

Progressively engaging accounts for how nurses, patients, and family members manage their relationships around care in acute care hospital settings. Central to the theory are nurses’, patients’, and family member’s descriptions of how they ‘come together’ in the course of patient care with varying levels of engagement. These levels of engagement are represented by three stages which include: focusing on tasks, getting acquainted, and building rapport.
At stage one, the focusing on tasks stage, engagement was affected by shared meanings and perspectives about structural conditions and personal factors (referred to as the terms of engagement), relevant to nurses, patients, and family members. Key structural conditions included high nurse workloads, patient acuity, prevalence of casual nurses, and language barriers. Personal factors included expressions of friendliness (e.g. smiling, chatting) versus more abrupt, indifferent, or “mean spirited” (P-13) responses. As nurses, patients, and/or family member(s) came together to manage relationships their initial individual and collective responses to the terms of engagement resulted in interpersonal dynamics that, in turn, facilitated or constrained their efforts to pursue personal connections at higher levels of engagement. Impersonal or business-like interactions could perpetuate the lowest level of engagement.

When nurses, patients, and family members experienced negative interpersonal dynamics they expressed dissatisfaction described as a lack of trust and respect about the ways their relationships were being managed. Negative interpersonal dynamics could result in patients and/or families ‘falling through the cracks’ or they could perpetuate the lowest level of engaging consistent with focusing on tasks, wherein the focus of care was on routines and skill competencies, without a sense of connection. The outcome of the lowest level of engagement was described as nurses “just doing the job”.

Conversely, when interpersonal dynamics were perceived positively and generated interest and concern for other(s) nurses, patients, and family members managed relationships by progressing from focusing on tasks to the next stage of progressively engaging, getting acquainted. When patients, family members, and nurses got acquainted they took further tentative steps towards getting to know each other. Nurses who progressed to getting acquainted were more likely to value incorporating personal elements of their patients and their families in
their care and to believe that undertaking tasks with patients and families did not exclude getting to know them. Patients and families who progressed to getting acquainted were building on their perceptions of nurses’ competence and their feelings of good will towards nurses. This stage was extremely time sensitive and efforts to get acquainted could be derailed by structural features, such as increased workload, despite the best intentions by nurses, patients, and family members.

When interpersonal dynamics continued to be positive, nurses, patients, and family members were more likely to progress to the third stage of progressively engaging: establishing rapport. At this stage, relationships were more reciprocal in nature, wherein nurses, patients, and family members shared a heightened sense of mutual trust and respect and exchanged gestures of recognition and support. The outcome of the highest stage of progressively engaging was expressed by nurses, patients, and family members in terms of satisfaction about the way they managed their relationships. Patients and family members felt a greater sense of well-being, while nurses felt they had done their jobs well and all groups described ‘doing the job with heart’. Negative interpersonal dynamics at any stage of the progressively engaging process could result in nurses, patients, and family members stepping back from the level of engagement achieved or, in more severe cases, opting out of the relationship altogether.

6.2 Progressively Engaging as a Contribution to Nursing Theory

Progressively engaging has been constructed from a rigorous process of systematic data collection and analysis that provided a means of explaining and interpreting a particular phenomenon or area of study (Glaser, 1978). More specifically, as a substantive theory, progressively engaging defines concepts and offers hypothesized explanations about relationships among concepts relevant to the nature of nurse-patient/family relationships in real life acute care hospital settings (Glaser, 1978, Hutchison & Wilson 1993; Jacelon & O’Dell,
The substantive theory of progressively engaging that has emerged from this study is viewed as a middle range theory that has the potential to inform family nursing practice in medical and surgical nursing units in acute care hospitals.

The theory of progressively engaging offers conceptual definitions (e.g. the stages of engagement) and hypothesized relationships (e.g. how conditions and factors affect levels of engaging) that provide insight into the development of nurse-patient/family relationships in acute care settings and the effects of structural conditions. Moreover, progressively engaging provides a more processural explanation for how complex interpersonal dynamics resulting from nurses’, patients’, and family members’ positive or negative perceptions about structural conditions and personal factors interact to influence movement on the engagement trajectory. Consequently, the concepts from the theory have the potential to be used to predict nurse-patient/family engagement in acute care medical and surgical settings.

To date, family nursing theories have paid little attention to the influence of structural conditions on nurse-patient/family relationships. Hartrick Doane and Varcoe (2005) maintained that to practice relationally nurses should: critically examining one’s habits of practice; incorporate an understanding of health as shaped by social conditions; and critically consider institutional working conditions and procedures that discourage a health promotion focus with families. These authors did not provide examples or empirical evidence to support how nurses’ (or patients’ or family members’) perceptions of systemic or contextual conditions discourage or encourage the development of nurse-patient and/or family relationships. Similarly, in their Calgary Family Intervention Model, Wright and Leahey (2005) stressed that when planning nursing interventions with families nurses must take into account the contextual constraints and resources of the larger system (e.g. hospital or health care industry) and their position in the
health care delivery system vis-à-vis the family” (p. 46). What contextual constraints and resources actually entail and how they affect the development of nurse-patient/family relationships has remained unclear. Because progressively engaging theory accounts for the meanings that nurses, patients, and family members attribute to systemic and contextual conditions associated with contemporary acute care medical and surgical units and how these conditions influence their willingness and/or ability to pursue personal connections to achieve higher stages of engaging, it advances our theoretical understanding of how nurse-patient/ family relationships develop in these settings.

6.3 Methodological Contribution

Developing the progressively engaging substantive theory by using symbolic interactionism as a theoretical lens and the grounded theory method makes a substantial contribution to family nursing research and theory development. By emphasizing symbolic interactionism, the theory of progressively engaging contributes to an interpretivist perspective of nurse-patient/family relationships because it captures how nurses, patients, and family members describe and define situations, assign meaning, make decisions, and act in relation to the other in the empirical world. By using the grounded theory method informed by symbolic interactionism to develop my theory, I have accounted for how participants’ interpretations of reality in acute care medical/surgical hospital settings are socially constructed. The use of grounded theory method enabled me to capture everyday meanings and patterns of behavior relevant to nurses, patients, and family members which in turn, led to my construction of the core variable, progressively engaging. My theory accounts for the basic social-psychological and social structural processes that explain how nurses, patients, and family members manage their relationships.
By structuring my sample to include family members, patients, and nurses, my theory enhances our conceptualizations about relationships around providing care to patients. Previous conceptualizations of family and family nursing have primarily, if not exclusively, been based on data obtained from nurses, patients, or family members in isolation from the other groups involved in the provision of patient care. This study is unique, because the theory of progressively engaging was developed from data obtained from nurse, patient, and family member participants and the core variable reflects all of their concerns around managing relationships during the provision of care in acute care hospitals.

Guided by the grounded theory method, which was informed by symbolic interactionism, the study findings advance current understandings about nurse-patient and/or nurse-family relationships as they occur in real settings. This is because the concepts and hypothesized conceptual relationships are grounded in nurse, patient, and family member participants’ descriptions of their perceptions about social interactions with others, and the environment or context in which these interactions occurred. The stages of progressively engaging represent how individual and collective meanings attributed to structural conditions, personal factors, and interpersonal dynamics influence how nurses, patients, and family members act in relation to the other. The theory of progressively engaging is, thus, an innovative interpretive approach to understanding and explaining the complex nature of nurse-patient and/or nurse-family relationships as they develop in acute care hospitals.

As a fresh way of conceptualizing nurse-patient and/or nurse-family relationships, my theory advances the dominant theoretical perspectives currently used to guide family nursing practice. It provides explanations to offset our current lack of understanding about how significant systemic and contextual conditions and personal factors affect nurse-patient/family relationships in acute
care hospital settings. In the sections that follow, I discuss the contribution of the progressively engaging theory toward addressing the questions about conceptualization of family, lack of attention to contextual features in acute care settings, and lack of theory about interactive processes used by patients, family members, and nurses.

6.4 Conceptualizations of Family

In the ongoing process of conceptualizing and theorizing about families and family nursing, two key questions that have long been debated include: Who is family? And, who is the focus of family nursing care? Previous research efforts aimed at responding to these questions have resulted in multiple definitions of family including the most dominant view of family as being self-identified or self-defined (Wright & Leahey, 2000; Wright, Watson & Bell, 1996). As well, a variety of conceptualizations of family nursing have emerged including: family as context (Friedman, Bowden & Jones, 2003; Wright & Leahey, 1991), family as unit (Robinson, 1995a; Wright & Leahey, 1991), and the family system nursing approach (Vaughan-Cole, 1998; Wright & Leahey, 2005). The popularity of family systems nursing has resulted in the prevailing practice expectation that nurses intervene with patients and families according to "who they say they are" (Wright, Watson & Bell, 1996; Wright & Leahey, 2005). Wright, Watson, and Bell, and Wright and Leahey have maintained that, by adopting this view of family, nurses can honor individual family members’ beliefs about their conception of family by including them in care.

In contrast, while nurse participants in my study described engaging with a variety of people whom they considered to be family or simply part of the patient’s support network, aside from hospital policies governing the disclosure of confidential patient information, the identity of persons at the patient’s bedside held little meaning in terms of influencing nurses’ decisions to engage or not engage with these individuals. In other words, family was not valued simply on the
basis of being family. Instead, the likelihood that nurses would engage with family members or other support persons was influenced by nurses’ perceptions of how these individuals could contribute to the well being of the patient. For example, nurses were more likely to initiate interaction with family members if they could provide an item (e.g. food from home) or a service (e.g. translation) that would enhance patient care and/or make patient care delivery easier. Nurses were also more likely to engage with family members or other support persons if they showed initiative in providing basic patient care. Only when patients were acutely ill and there was threat to life did the likelihood of nurses shifting their focus to include family member(s) in care, regardless of their contributions, increase.

How family was conceptualized in family nursing theory held little meaning or value in terms of guiding nurses’ decisions to manage their relationships with family member(s). Instead, nurse participants described a complex process, in which their decisions to engage with a patient and/or their family were influenced by their perceptions of the unique terms of engagement (structural conditions, and personal factors) relevant to and interpersonal dynamics occurring within those relationships. These perceptions facilitated or constrained nurses’ willingness to pursue higher stages of engagement with patients and/or families in the context of providing nursing care regardless of who they were. For example, nurses were less inclined to engage with patients and family members whom they perceived as overly demanding or disrespectful of nurses, the sick family member, or other patients. Several nurse participants also stated that they were unwilling to ‘get in the middle’ of dysfunctional family situations.

My findings stand in opposition to family systems theorists who maintain that there is no such thing as a dysfunctional individual or family (Wright, Watson & Bell, 1996). Wright and Leahey (2005) and Wright, Watson, and Bell (1996) maintained that problems reside between persons in
language and argue that nurses' judgments of truth about others based on clinical observation alone trivializes the problem and limits other possibilities. Wright, Watson, and Bell emphasized that when intervening with patients and families nurses need to challenge their own constraining beliefs that underlie their perceptions of patient and/or family behavior as dysfunctional, resist privileging their observations and judgments as 'truth', and focus more on honoring patients' and family members' perceptions. These suggestions imply that nurses' perceptions should be minimized or ignored.

Contrary to theoretical perspectives that privilege family members' conceptualizations of family as the focus for family nursing care, the theory of progressively engaging accounts for nurses' and patients' perspectives about the people who constitute the family. Moreover, my theory describes how nurses, patients, and family members engage on the basis of their perceived responses to each other and the environment, thereby extending current theoretical perspectives by identifying key factors in facilitating family nursing that move beyond how family is defined. The findings add nuance to the approach used by Wright, Watson, and Bell (1996). They focused on how nurses’ ideas about who and what constitutes family affects how they offer assistance to families and argued that family health professionals need to find a definition of family that extends beyond the traditional criteria of blood, adoption, and marriage.

A common thread for family nursing theories is that nurses form partnerships, collaborate, interact with, or otherwise include families as a focus of care (Bell, 2004; Friedman, 2003; Wright & Leahey, 2005). Based on the premise that "illness is a family affair", Bell (2004), a proponent of family systems nursing, argued that nurses in hospital settings must embrace the conceptualization of families as 'the new patient'. My findings refute this emphasis on family as focus of care, because my participants unanimously expressed their belief that the well-being of
patients, not families, was the main priority. Nurses were thus unlikely to engage with family members whom they perceived as having a negative influence on the patient's health or well-being and families and patients did not expect nurses to treat families as the 'new patient'. In terms of nurses setting the agenda for family nursing, they were more likely to engage with family members whom they perceived as being supportive (e.g. helping the patient with care, maintaining a positive attitude, being cooperative with nursing care) and under conditions where the patients' condition was critical or terminal when they regarded interaction with family members as very important.

The widely recognized and accepted systems-based Calgary Family Assessment and Intervention Model offered by Wright and Leahey (2005) directs nurses to think reciprocally about health, illness, and families and about patients, families, and nurses. By incorporating a therapeutic-collaborative process with families, nurses co-evolve nursing interventions that are most likely to change the family's presenting problem. Hartrick Doane and Varcoe (2005) encouraged nurses to engage in a process of being in relation personally, socially, physically, intellectually, and spiritually to other human beings and the environment. Hartrick Doane and Varcoe maintained that a relational approach enhances nurses' abilities to recognize and honor differences and similarities, respond to the uniqueness of people and families, and enlist families in the knowledge development process.

The theory of progressively engaging indicates that, although nurse participants described engaging with a variety of people considered to be part of the patient's family or support network and several acknowledged that they believed working with families yielded more positive health outcomes for patients and/or family members, nurses did not always collaborate or otherwise engage with families just because they had an ill family member in the hospital. Moreover,
nurses did not achieve the same level of engagement with all patients and/or family members. Nurses' willingness or perceived ability to engage with patients and families was dependent on their responses to conditions and/or factors associated with the context in which the nurse-patient/family relationship occurred. Nurses' motivation to engage with family members was enhanced by working with acutely ill patients, especially when there was threat to life. In less acute situations, nurses relied on patients and family members to initiate interaction with them with questions or concerns. Nurses indicated that they were more likely to routinely include family members in discharge planning, but they preferred to engage with the family member identified as the primary care giver or with whom the patient would be living.

In the context of a relational view, Hartrick Doane and Varcoe (2005b) have emphasized nurses' awareness of how they influence families' responses to them and to their experiences. Although like progressively engaging, McQueen (2000) acknowledged the contribution made by both patients and nurses to the development of nurse-patient relationships, she stressed the importance of nurses presenting themselves to patients in a way that encourages therapeutic nurse-patient relationships. None of these authors incorporated nurses' perceptions of patients and/or family members, structural conditions, or personal factors in the process of maintaining their relationships.

In contrast, my theory contributes to the relational literature by explicitly describing and explaining how structural conditions and personal factors influence how nurses, patients, and family members perceive and relate to each other around the provision of care in acute care hospital settings. Specifically, nurse, patient, and family member participants in this study described managing their relationships by pursuing higher levels of engaging with each other only when they perceived each other in a positive light, that is, when some level of personal
connection was developed. Personal factors that conveyed interest and concern were important to
enhancing nurses’, patients’ and family members’ willingness to pursue personal connections
with each other. Although positive personal factors served as an important term of engagement,
in isolation, they were not adequate to facilitate or sustain nurse-patient and/or family
relationships at higher levels. Nurses were unlikely to move beyond focusing on tasks if they
were too busy with more acute patients and their family members. Similarly, patients and family
members were less willing to pursue more personal connections with nurses who they perceived
as always ‘rushed off their feet” because they didn’t want to bother them. In these cases, patients
and family members fell through the cracks. Other studies have only reported that patient and
family member participants indicated that they were more likely to engage with nurses who
smiled, were friendly, and/or conveyed other personal factors that were perceived by patients and
families as conveying interest and concern (Astedt-Kurki, et al., 2001; Duhamel & Dupuis, 2004;
Hupcey, 1998; Robinson & Wright, 1995; Webb & Hope, 1995)

Although the importance of viewing the nurse, patient, and family relationship through a
relational lens has been increasingly reported in the literature, there has been no empirical
evidence provided about how a relational stance can guide family nursing practice in acute care
hospital settings. Hartick Doane and Varcoe (2005b) based their relational view of family
nursing on their experiential perspectives rather than on empirical evidence. While these authors
resisted identifying a particular theoretical framework for guiding relational family nursing
practice they emphasized that how nurses see, think, assess, and intervene with families makes
practice relational. My theory of progressively engaging provides evidence to support an
expanded view of relational family nursing that honors patients’ and families’ ways of being and
acting with nurses. It does this by demonstrating that higher levels of progressively engaging –
levels that are consistent with doing the job with heart - are not attained simply by attending to how nurses view and work with patients; how patients and families view and work with nurses is equally important.

Rather than starting from the position that illness is a family affair (Wright & Leahey, 2005; Wright, Watson & Bell, 1996) and assuming that nurse-family collaboration will follow, my theory accounts for conditions beyond illness that influence how nurses conceptualize patients and families and work with them. It accounts for stages in the engaging process that occur as nurses and patients and/or family members come together around care in acute care hospital settings. My theory advances current understandings about how the meaning nurses and patients and families assign to illness and degrees of illness (acuity) interface with other structural conditions, personal factors, and interpersonal dynamics to facilitate or constrain their willingness to move to higher levels of engaging or step back from a level of engaging already achieved.

Although nurses are encouraged to think reciprocally about health and illness and family (Wright & Leahey, 2005), a major contribution of my theory is that it provides insight into how nurses’ efforts to think reciprocally about health and illness and family are dependent on their perceptions of the terms of engagement and interpersonal dynamics, influencing how they choose to manage their relationships with patients and/or family members. Moreover, my theory emphasizes that nurses’ efforts to engage with patients and families is also dependent on patients’ and family members’ perceptions of the terms of engagement and interpersonal dynamics influencing their decisions about how to manage their relationship with nurses. For example, nurses indicated that they were more inclined to ‘go the extra mile’ with patients and
family members who they perceived as respectful and who conveyed appreciation for the nurse’s efforts.

Progressively engaging also accounts for how nurse-patient and/or nurse-family member relationships can be ‘fast-tracked’ through the stages of engagement to the third and highest stage, establishing rapport. The theory indicates that this can occur in circumstances of positive conditions, personal factors, and interpersonal dynamics. For example, nurse participants described allocating more time and effort toward establishing personal connections with patients and/or their family members who were friendly and conveyed appreciation for nurses’ efforts. From the perspective of nurses, patients and family members could contribute to fast-tracking by conveying respect for nurses’ efforts to manage their time by making efforts to help themselves, timing questions appropriately, and prefacing their questions with an acknowledgement of the demands on nurses.

Patients and family members could resist nurses’ efforts to engage with them by not being willing to cooperate with care, withholding information, indicating a preference to speak to the doctor. Patients and family members could also sabotage nurses’ efforts to engage with them by being overly demanding of nurses’ time and attention. Moreover, patients and family members were more likely to respond with resistance to nurses who made little effort to engage with patients and families or ignored patients’ and families’ efforts to engage with them.

Where the Calgary Family Assessment Model (CFAM) and Calgary Family Intervention Model (CFIM), (Wright & Leahey, 2005) set nurse-patient and nurse-family collaboration as the gold standard for practice and offer approaches for intervening with families to achieve this goal, my theory of progressively engaging acknowledges that many nurses, patients, and family members do not achieve collaborative relationships. Instead, nurses, patients, and family
members achieve various stages of engagement that reflect different levels of personal connection, which can be reversed or stopped by stepping back or opting out. Based on the trajectory of engagement, collaboration corresponds most closely with stage three of the progressively engaging - establishing rapport – a stage that is achieved only if nurses and patients and/or family members have been willing to get acquainted and have established some mutual respect and trust. If nurses, patients, and family members do not achieve establishing rapport it is because, based on their individual and collective responses to the structural conditions and personal factors and the interpersonal dynamics, they have decided to stay at focusing on tasks, have stepped back from a higher level of engaging, or have opted out of engaging altogether.

6.4.1 Pragmatism.

Although ideal goals that drive dominant conceptualizations of family nursing are admirable, they fail to recognize the work conditions that constrain or facilitate nurses’, patients’, and family members’ efforts to achieve that ideal in practice. In contrast, my theory of progressively engaging explains how nurse-patient and nurse-family member relationships develop in the conditions that characterize acute care settings. It is an ‘everyday practice theory’. It is a theory to which nurses in everyday practice can relate. This is because I constructed progressively engaging from nurse, patient, and family member participant descriptions and my observations about how they interacted with each other. Since the theory is grounded in ‘everyday’ situations (Atkinson & Housley, 2003; Charon, 1979; Prus, 1996), it reflects a pragmatic approach used by nurses, patients, and family members to conceptualize one another and manage their relationships.
Hartrick Doane and Varcoe (2005b) hypothesized that through pragmatic inquiry nurses inquire into and question their own experiences, the experiences of others, existing theories and research, and the contextual and structural elements that shape their experiences and practice (p. 84). Pragmatist philosophies emphasize the importance of exploration and interpretation of human engagement in the social and natural world (Atkinson & Housley, 2003), and regard human beings as not "passively shaped" (Charon, 1969). While these perspectives contribute to a theoretical understanding of how nurse-patient and/or family relationships may be enhanced, they do not achieve a level of specificity that helps nurses understand how nurses 'live in their practice' and how patients and families contribute to nurses' perceptions.

My theory of progressively engaging clearly links nurses' perceptions of the clinical environment (structural conditions and personal factors) and of patients and family members to their decisions about whether and to what extent they are willing to pursue personal connections with patients and family members. How nurses manage their relationships with patients and family members affects the development of interpersonal dynamics which, in turn, influence nurses' willingness to pursue personal connections at higher levels of engagement. To this extent, progressively engaging fits with Friedman, Bowden and Jones' (2005) suggestion that family and family nursing is ultimately defined on the basis of how nurses work with families.

Central to my theory of progressively engaging are patients' and family members' perceptions of nurses, structural conditions, and personal factors and their responses when they decided whether to pursue engagement with particular nurses in acute care settings. Patients and family members were not always willing to pursue personal connections with nurses. They were more likely to initiate interaction with nurses whom they perceived as friendly, having a sense of humor, being willing to chat, and not rushing in and out the room quickly. Progressively
engaging underscores the relational quality of nurse-patient and/or family member interactions by emphasizing the interactions among nurses', patients' and family members' perceptions of the influences of structural conditions, personal factors and interpersonal dynamics on relationship development (e.g. movement through stages of engaging, stepping back or opting out).

While Hartrick Doane and Varcoe (2005a) tipped the balance of power and responsibility for relational family nursing towards nurses' 'way of being' with families, my theory of progressively engaging provides evidence that patients' and family members' way of being with nurses also influenced the level of engagement achieved in relationship. My theory explicates how individual responses to systemic and contextual conditions, personal characteristics, and kinds of interactions create interpersonal dynamics that led to participants either stepping back from relationships or pursuing higher stages of engaging. It presents nurses, patients, and family members as active participants in the engaging process. As discussed in the next section, the theory of progressively engaging extends our understanding about the effects of systemic and contextual features of the work environment on nurses', patients' and family members' relationships.

6.5 Accounting for Systemic and Contextual Features of the Work Environment

Progressively engaging explains how structural conditions affect nurse-patient and/or family relationships in acute care hospital settings. The theory accounts for nurses’, patients’, and family members’ perceptions of ‘nurse busyness’. Nurse busyness captures the meaning of time for nurses, patients, and family members in response to the meanings they assigned to structural conditions and their positive or negative effects on their decisions to engage. This is an important contribution, because there is a dearth of empirical evidence explaining how structural conditions
affect nurse-patient and nurse-family relationships in acute care hospital settings. Moreover, the concept of nurse busyness, as an expression of time, remains largely unexplored and under-theorized in the nursing and family nursing literature.

Many authors have linked such conditions as nursing shortages, rapid patient turnover, and increased patient acuity with increased demands on nursing time which, in turn, has been thought to act as a barrier to establishing nurse-patient and nurse-family relationships (Burke, 2003; Friedman, 2003; Greenglass & Burke, 2002; Levine & Zuckerman, 2000; McGillis Hall & Kiesners, 2005). Duhamel (1995) argued that, in response to economic restraints and nursing workload, nursing administrators place greater emphasis on physical nursing care of patients. Burke (2003) wrote that hospital restructuring has affected hospital-based nursing staff in terms of increased workload and patients requiring greater attention, which has resulted in an erosion of a sense of professional accomplishment among nurses. Levine and Zuckerman (2000) maintained that nurses’ attempts to engage families in meaningful ways can be thwarted by organizational requirements, short hospital stays, and other factors that result in lack of nursing time and ‘force’ nurses and families into adversarial positions.

My theory supports the conclusions of authors (Tapp, 2000; Wright & Leahey, 2005) that link conditions such as inadequate staffing to decreased available nursing time in acute care hospital environments and to negative effects on nurse-patient and nurse-family relationships. However, because progressively engaging was developed using grounded theory and a symbolic interactionist lens, it provides a vehicle for understanding how socially constructed meanings about time and other structural conditions in the acute care hospital settings affect the development of nurse, patient, and family relationships. Meanings assigned to conditions influence nurses’, patients’, and family members’ decisions about how to manage their
relationships with each other, including the time they are willing or, in the case of nurses, able to invest toward pursuing personal connections.

6.5.1 Time.

Recent commentaries about the ways that structural conditions constrain family nursing practice in acute care settings have emphasized the need for nurses to alter their constraining beliefs about families and family nursing. Wright and Leahey (2005) maintained that the most common reason offered by nurses for not involving families in their practice was because they lack time or are too busy. They argued that nurses’ perceptions about time were based on their constraining beliefs about families and that nurses simply needed to modify their beliefs about families, by recognizing that even small amounts of time spent with families could be beneficial. In contrast, my theory of progressively engaging accounts for how the meaning nurses ascribe to structural conditions affects how they assign meaning to patients and families and engage with them. It does not present engaging with family members and patients as an all or nothing response, but as a trajectory that includes progressively higher stages of engaging which patients, family members, and nurses can move up and down. How nurses allocate their time for pursuing more personal connections affects whether the participants achieve higher levels of progressive engagement. Time becomes less important as relationships approach the establishing rapport stage, where participants share feelings of mutual trust and respect that transcend time.

Typically, the notion of time is viewed in the nursing literature as a commodity in short supply in contemporary acute care hospitals (Burke, 2003). My theory of progressively engaging acknowledges that, in the context of the acute care hospital settings, patients, family members, and particularly nurses view time as a limited resource. Time can be regarded as a commodity which requires careful distribution or allocation (Hall, 1998). Progressively engaging relates
structural conditions (as well as personal factors and interpersonal dynamics) to time allocation decisions by nurses that, in turn, affect how much time they may be willing to invest engaging with patients and families. Focusing on tasks represented nurses' negative responses to lack of time to meet all the demands placed on them. Although nurse participants described having little control over amount of time vis-à-vis the structural conditions in the hospital they made decisions about how they allocated their time.

Nurses' perceptions of time as a limited resource were influenced by systemic conditions, such as staff shortages or high workload. Contextual factors (e.g. language barriers), personal factors (e.g. unfriendly patients or family), or interpersonal dynamics (e.g. disrespectful patients/family members) also influenced nurses' time allocation decisions. Patients' and family members' perceptions of time in terms of nurse busyness could also positively or negatively influence their willingness to engage with nurses. They could respond negatively to their perceptions of nurses' busyness by avoiding asking questions. Their responses decreased the likelihood that nurses who are busy will engage with them, beyond focusing on tasks.

Other commentaries on nurse-patient and/or nurse-family relationships have emphasized that nurse-patient and nurse-family relationships develop over time. In other words, relationships are an outcome of amount of time invested or what Hall (1998) referred to as a view of time as a form of personal currency. Morse (1991) linked the type of nurse-patient relationship to contact over time; the more time that nurses and patients spend together, the more connected the relationship will become. Hupcey (1998) maintained that relationships between nurses and families take time to develop or they may never develop adequately. Several authors have argued that lack of rapport between patients and nurses is related to shorter contact time as a result of heavy workloads and other conditions associated with the acute care hospital setting that are
perceived to reduce nursing time for interactions with patients and families (Astedt-Kurki et al., 2001; Hagerty & Pausky, 2003; McQueen, 2000).

My theory of progressively engaging supports the link between systemic conditions associated with contemporary acute care hospital settings and the difficulty nurses, patients, and family members experienced in engaging beyond focusing on tasks. When nurses responded to structural conditions by perceiving that they had inadequate time to get to know patients and families and patients and families felt ‘like a number’ there was an increased likelihood that negative interpersonal dynamics constrained their relationships to lower levels of engaging. The problem was compounded by nurses’ perceptions that their efforts to pursue more personal connections with clients were unsupported by the hospital or the health care system, which contributed to their feelings of frustration and dissatisfaction with their work.

My findings are consistent with those of other authors who have observed that relationships between nurses and patients or nurses and families are less likely to develop when, due to nursing shortages, nurses have unrealistic time schedules to compete physical tasks, as well as to interact with patients (Finch, 2005; Majasaari, et al. 2005; Williams & Irurita, 2004). Benner (2004) maintained nurse-patient and nurse-family relationships are endangered due to bureaucratic goals aimed at cost-efficiency that clash with nurses’ efforts to meet and respond to others. Finch (2005) argued that, by decreasing nurse-patient ratios and overtime as well as by increasing recruitment and improving the safety of the workplace, nurses’ ability to communicate caring would be enhanced and increased job satisfaction and decreased nursing burnout would result. My study has shown that nurses who perceived that they were forced to focus on tasks because of systemic conditions such as high workload, described feeling less satisfied with their work.
Although Wright and Leahey (2005) acknowledged that secondary to such conditions as budgetary constraints, increased acuity, and staff cutbacks 'time is of the essence' in nursing practice, they emphasized the need for nurses to embrace the belief that involving families would not take a lot of time if it became a part of nurses’ practice routines. My study findings suggested that perceptions of busyness did not constrain all nurse-patient and nurse-family relationships. Some nurses, patients, and family members were successful in their efforts to get acquainted and others progressed to the highest stage of progressively engaging, establishing rapport, despite negative systemic conditions. Those nurses who were more willing to combine performing tasks with getting a feel for patients and families progressed to higher stages of progressively engaging. They did this by explaining what they were doing, addressing clients by name, acknowledging the presence of family members at the bedside, smiling and being cheerful, engaging in social chatting, and taking time to listen and answer patients’ and family members’ questions. Patients engaging with such nurses reported feeling cared about, respected, and valued and reciprocated by conveying increased trust and respect towards them. These findings support Wright and Leahey’s (2005) claim that, even small amounts of time, when used to acknowledge, get to know, and intervene with families can enhance nurse-family relationships, promote patient and family healing, and reduce suffering.

My findings do not support Wright and Leahey’s (2005) argument that nurses need to involve families as part of their honored routine. Instead, my theory suggests that nurses’ decisions to use time at the bedside to pursue more personal connections were influenced by their perception of patients’ and families’ positive personal factors, such as respectful communication and demonstrations of appreciation. Nurses’ behaviors were also influenced by family members’ behaviors; they were more likely to pursue personal connections with family members they
observed making an effort to help themselves or their family member. Even in the presence of language barriers, if nurses observed that patients and families were making an effort with them, they were more likely to pursue connections.

My findings suggested that positive contextual conditions and personal factors could be overridden by systemic conditions that reduced the availability of nurses’ time and were outside their control. Nurses who were willing to invest time to engage were sometimes forced to respond to time restrictions. Moreover, when patients and families were demanding, families were disrespectful of patients, nurses, and hospital/unit rules and policies, or families and patients were non-compliant and uncooperative nurses were less likely to allocate time to get to know them. Nurses who focused on medical definitions of acuity were also less inclined to invest time getting to know patients they regarded as stable - even when the patients made an effort to develop positive interpersonal dynamics with them.

Citing the unpublished doctoral dissertation of Rankin (2004), Hartrick Doane and Varcoe (2005a) noted that Wright and Leahey’s ‘15 minute interview’ was an example of a ‘business approach’ where nurses are encouraged to manage discourses of time and efficiency which are challenging to nurses efforts to involve families in care. Hartrick Doane and Varcoe maintained that Rankin’s work challenges Wright and Leahey’s (2005) contention that nurses need to alter their beliefs and find more efficient ways to assess and interact with families. Rankin argued that a better understanding of the pressures of the environment (increased acuity, increased workload, deskilling of the workforce) that leads nurses to form such beliefs is needed.

My theory of progressively engaging advances our understanding of nurses’ perceptions about the structural conditions, which influence meanings nurses assign to work conditions and their decisions about allocating time to pursue personal connections with patients and families. It
also explains how their decisions influence patients' and families' perceptions of nurse busyness and their willingness to engage with nurses. These are important findings because they offer insight into how meanings associated with various systemic (e.g. nursing shortages) and contextual (e.g., increased acuity) conditions in acute care hospital environments come together to influence nurses', patients', and family members' decisions to manage their relationships with each other.

The literature has documented that patients and families notice nurse busyness and perceive nurses' lack of time to interact with them as negatively affecting the development of nurse-patient and nurse-family relationships in acute care hospital settings (Astedt-Kurki et al., 2001; Hupcey, 1998; Tapp, 2000; Wright & Leahey, 2005). Astedt-Kurki et al. (2001) for example, reported that family members of ill patients perceived interaction with nurses to be difficult when nurses had too little time for interaction. Families also reported feeling 'upset' and frustrated when nurses limited involvement with them by 'maintaining an efficient attitude' (e.g. giving the impression of busyness, focusing on physical acts, spending minimal time in the patients room, not responding to questions); they perceived this approach by nurses as a 'power play' to retain control (Hupcey, 1998).

The findings from the literature support my findings about families' and patients' negative responses to their perceptions of nurse busyness; however, the theory of progressively engaging adds to the discourse by illuminating not only how patients' and family members' responses to structural conditions facilitate or inhibit their willingness to engage with nurses, but also how patients' and family members' responses influence nurses' willingness to initiate interactions with them. My theory addresses the gap in the literature by accounting for the effects of structural conditions (and personal factors) from perspectives of nurses, patients, and family
members. This is a significant contribution to our understanding about how nurses, patients, and families affect and are affected by their responses to structural conditions in the acute care hospital environment. The circular development of patients’ and family members’ unwillingness to ask nurses who are busy questions and nurses’ perceptions that when they are busy they depend on patients and family members to signal their need for a nurse by asking questions suggests dynamics that contribute to a lack of engagement.

6.5.2 Acuity.

High patient acuity is a contextual condition that is commonly linked by the literature to high nurse workload and stress levels. For example, in their review of working conditions of hospital nurses, Baumann, O’Brien-Pallas, Armstrong-Stassen, et al. (2001) associated high levels of patient acuity, nurse workload, and understaffing to inadequate patient care and high stress levels among nurses. The theory of progressively also links nurses’, patients’, and family members’ perceptions of high levels of acuity in acute care hospital settings to negative effects on nurse-patient and/or nurse-family relationships. It extends the literature by explaining the mechanisms by which patient acuity affects relationships. For example, nurses who perceived themselves to be busy described allocating more time to sicker patients and their family, while minimizing their attention to patients and family members that were considered stable. My theory links patient acuity as a contextual condition to nurses’ willingness to ‘fast-track’ their relationships with patients and/or family members toward higher levels of progressively engaging. With greater threats to a patient’s life, nurses are more likely to manage their relationship with patients and or family members by quickly moving past getting to know them to establishing rapport. Moreover, my theory explains the effects of patient acuity on patients’ and family members’ behaviors around engaging with nurses. When patients and family members perceived nurses
were busy because they were taking care of 'sicker' patients they avoided or delayed asking nurses questions or seeking their assistance – even when it was needed. Patient acuity could increase the likelihood that nurses stepped back from higher levels of engaging with stable patients and their family members so they could 'save' time for acutely ill patients. When nurses, patients and family members were in the stages of becoming acquainted or establishing rapport, patients and family members were more willing to 'cut the nurses slack'. They were more understanding and supportive of nurses spending more time with sicker patients and their families. Thus, my theory not only accounts for how acuity operates, but also accounts for the reduction in the significance of time invested in engaging, as participants reach higher levels of progressively engaging.

6.5.3 Increases in casual nursing staff.

The literature has linked increases in the numbers of casual nurses in the nursing workforce to permanent full-time nursing staff’s perceptions of increased stress and workload and decreased patient safety (Richardson & Allen, 2001). To date the effects of increased numbers of casual nurses have remained poorly understood. Based on the hypothesis that increased casual workers result in increasingly difficult workplace communication (including communication with patients) that negatively affects client outcomes, Batch, Barnard and Windsor (2006) have proposed an ethnographic study to explore relationships between increasing numbers of casual nurses and communication needs of full time and casual nurses.

My theory of progressively engaging provides evidence about the effects of nurses’, patients’, and family members’ perceptions of increased casual staff on the development of nurse-patient and nurse-family relationships in acute care hospital settings. Some nurse participants indicated that nursing shortages and staffing issues have increased the use of casual nurses, whom they
perceived as more task-oriented. They attributed the casual nurses' focus on tasks to being less familiar with unit routines and being exposed to patients for inadequate time to get to know them. Patient and family members consistently indicated that they were less inclined to get to know nurses who only “pass through” or whom they see only once or twice during their hospital stay. Patients and family members also indicated that they perceived casual nurses as being less competent and more interested in ‘just getting the job done,’ without doing anything extra.

My study findings suggest that increased numbers of casual nursing staff may be a structural condition in acute care hospital settings that constrains nurse-patient and nurse-family levels of engagement in relationships. Minimal contact between nurses and patients and families provides few opportunities for them to get a feel for each other. Getting a feel for each other is a necessary prerequisite for developing positive interpersonal dynamics that will support the movement of relationships toward getting acquainted. Because patients and families assessed nurses’ competence on the basis of their skill performance, as well as how the nurse engaged with them, they were less inclined to perceive casual staff as competent and trustworthy. My theory of progressively engaging accounts for how nurses', patients,’ and family members’ responses to increased numbers of casual nurses influence the development of neutral or negative interpersonal dynamics that prevent nurse-patient/family relationships from moving beyond the focusing on tasks stage of progressively engaging.

6.5.4 Influences of structural conditions on personal factors.

McQueen (2000) explored the development of therapeutic nurse-patient relationships in the context of cost-containment strategies on increased efficiency that facilitate nurses’ efforts to ‘get on with the business of physical care’ but that inhibit human interaction. McQueen theorized about nurses’ and patients’ reception of the responses of others in interaction as an influence on
the development of relationships between them. While verbal and behavioral responses are important, so too are personal qualities although personalities of nurses are rarely accounted for in practice (McQueen, 2000; Smyth, 1996). Progressively engaging supports and extends the McQueen’s work by explaining how perceptions of structural conditions and personal factors associated with nurses, patients, and family members can influence their willingness to engage with one another. For example, while nurses’ perceptions of structural conditions influenced their decisions around the allocation of time, nurses were also influenced by their perceptions of patients’ and family members’ personal factors (e.g. appreciation for nursing care, supportive of nurses, and supportive of the patient) and interpersonal dynamics, which represented nurses’, patients’, and/or family members’ responses to each other, resulting in a positive or negative perception of the other in relationship. Even if the structural conditions were positive (e.g. lighter patient load, sufficient staffing), negative interpersonal dynamics between family members and the nurses, created conditions where nurses were unlikely to engage with them even at the focusing on tasks stage. Under those conditions, the family members fell through the cracks.

My theory extends our understanding of contextual conditions by accounting for times when nurses perceived that they were busy, but on the basis of positive personal factors associated with some patients and family members (e.g. they were friendly, patient, respectful, and cooperative/compliant) they were willing to invest time to get to know the patient and the family members. Short interactions, like a simple acknowledgement, generally contributed to a positive interpersonal dynamic that increased the likelihood that nurse-patient and nurse-family relationships could progress beyond focusing on tasks. When patients, nurses, and family members perceived structural conditions and personal and interpersonal factors positively they were more willing to manage their relationships by achieving higher levels of engagement and
were often able to fast-track their relationship to the establishing rapport stage of engaging.

The theory of progressively engaging challenges the assumption that structural conditions that lead to nurse busyness result in inadequate or incomplete patient/family care and or interfere with developing positive relationships in all cases; it explains that nurse-patient and nurse-family relationships are not only dependent on structural conditions but also on interactions among nurses’, patients’, and family members’ perceptions of structural conditions, personal factors, and interpersonal dynamics.

6.6 Interactive Processes

The literature has been lacking in explanations about how nurse-patient and nurse-family interactions occur in clinical practice settings, which is commonly identified as a root cause of the disparity between family nursing theory and nursing care inclusive of families (Bell, 1995; Vaughan-Cole, 1998; Griffin-Ward & McKeever, 2000). My theory of progressively engaging provides an explanation about the nature of nurse, patient, and family relationships and the circumstances under which nurses and patients and family members engage around care. Each stage of the theory accounts for different responses by nurses, patients, and family members to structural conditions, personal factors, and interpersonal dynamics and their positive or negative effects on movement down or up the progressively engaging trajectory. The theory also acknowledges the contributions of nurses, patients, and family members, through their willingness to engage in more personal connections, to the process of progressively engaging.

Although limited to the perspectives of nurses and families, Hupcey’s (1998) ‘model of strategies’ used by nurses and families that developed or inhibited nurse-family relationships supports the strategies I describe in my theory. For example, Hupcey found that when nurses depersonalize the patient and family (e.g. not calling them by name) and/or maintain an efficient
attitude (e.g. by acting too busy to answer questions, performing only physical acts of patient care) nurse-family relationships were inhibited. Withholding information, becoming over or under involved in care, and displaying a lack of trust in the nurses were examples of strategies Hupcey identified that were used by family members and inhibited the development of nurse-family relationships. Hupcey also indicated that when both nurses and families make an effort to convey trust in the other it promotes the development of nurse-family relationships. My theory extends Hupcey’s findings by accounting for patients’ as well as nurses’ and family members’ perspectives about how such strategies contribute to negative interpersonal dynamics that inhibit their willingness to engage with each other.

Although the strategies identified in Hupcey’s (1998) model contribute to our understanding about the relationship between strategies used and the development of relationships, her model does not clarify interactive processes that occur between nurses and families and affect how they respond to one another when they use one particular strategy over another. In contrast, my theory of progressively engaging describes a complex and dynamic relational process that acknowledges how nurses, patients, and family members, based on their positive or negative responses to each other, as well as structural conditions, managed their relationships with each other in each stage of engaging. The theory indicates that the meaning nurses assign to their workload and patient acuity influences their management of their relationships with patients and families by focusing on tasks or pursuing more personal connections.

Morse (1991) described nurse-patient relationships as being either mutual or unilateral. In mutual relationships, the degrees of function are implicitly agreed upon. In unilateral relationships, there is unwillingness or inability on the part of either the nurse or the patient to develop the relationship to the level desired by the other. Morse linked the development of the
relationships to time, needs and desires of the nurse and patient, and personality factors.

According to Morse, nurses and patients use various strategies to increase their involvement in relationships. Nurses demonstrate commitment (e.g. notes that personalities ‘click’, responds to patient as person, establishes common ground, gives patient time, and anticipates needs), perseveres, and becomes involved (patient advocate, bends rules). Patients base their decisions to trust nurses on their assessment of nurses as good people and good nurses (Morse).

Progressively engaging extends Morse’s (1991) work by incorporating the perspectives of patients and families, as well as nurses, and including conditions and interpersonal dynamics that affect nurses’, patients’, and family members’ assessments of each other and influence their willingness to engage. In particular, the category, ‘terms of engagement’, introduced in my theory incorporates the conditions and personal factors at various levels of engagement that affect the interpersonal dynamics between them. The conditions in my theory that affect nurses’, patients’, and family members’ efforts to engage, include language barriers, workload, nursing staff shortages, and acuity.

My theory refutes Morse’s (1991) claims about nurses’ and patients’ perseverance. Morse argued that, in unilateral relationships, nurses will persevere with patients who are ‘difficult’, until they change their behavior or the nurse learns to tolerate them and patients will engage in coercive behaviors in an effort to convince the nurse to become more involved. My theory suggests that positive interpersonal dynamics increase the likelihood that nurses, patients, and family members will pursue personal connections that can move their relationship to higher levels of progressively engaging, but also indicates that nurses, patients, and family members may persevere only under particular conditions. It provides the categories of stepping back, falling through the cracks, and opting out that describe patients, nurses, and family members
disengaging under negative conditions, personal factors and/or interpersonal dynamics, even if they had been committed to the relationship. Those conditions may not only constrain efforts to engage but also prevent them from engaging at all. In short, my theory suggests that patients and families do fall through the cracks and many nurse-patient, and particularly nurse-family relationships never develop or never progress beyond focusing on tasks.

6.6.1 Fast-tracking.

My theory of progressively engaging provides evidence to support Morse's (1991) observation that nurses will accelerate the process of relationship development when they perceive patients to be in extreme need or crisis; however, it also extends Morse's description of 'extreme need' or crisis by describing the process of 'fast-tracking' and explicating more fully the conditions, personal factors, and interpersonal dynamics that affect this process. My theory suggests that nurses' decisions to dedicate more time to engage with sicker patients and their family members influenced their decisions to limit their efforts to pursue more personal connections with stable patients. This perpetuated lower levels of engagement with some patients and family members and increased the likelihood that some patients and family members fell through the cracks.

My theory suggests that the meaning assigned to acuity may have also influenced nurses to step back from engaging with some patients and families, so they could devote their time and attention to sicker patients. That could have positive or negative effects on the nurse-patient and/or nurse-family member relationship depending on the nature of the relationship already established. In nurse-patient and/or nurse-family member relationships that were moving toward or had achieved higher stages of progressively engaging, patients and family members were willing to overlook or tolerate nurses stepping back from engaging with them in order to spend
more time with sicker patients and families. When nurses, patients, and family members in relationship were unable or unwilling to move beyond the focusing on tasks stage of engaging, those patients and family members were less willing to submit to what they perceived as being "ignored" or "treated like just a number" by nurses who were too busy attending to other patients – even if those patients were sicker or in greater need of nursing care.

In my theory, fast-tracking was primarily nurse-driven and based on acuity and other structural conditions. However, patients’ and family members’ efforts toward establishing positive interpersonal dynamics with nurses could accelerate movement of the nurse-patient/family member relationship toward the getting acquainted and establishing rapport stages of engaging. For example, when patients and/or family members were especially friendly, respectful, appreciative, and were highly motivated to ask questions, cooperate with nurses and help in their own or their family member’s care, nurses were more inclined to make time to engage with them resulting in the relationship fast-tracking to higher levels of engaging on the trajectory.

6.6.2 Stepping back.

Stepping back, which I described in progressively engaging, builds on Morse’s (1991) description of unilateral relationships. Morse found that unilateral relationships were characterized by a lack of mutuality, wherein the nurse or the patient demonstrated commitment to the relationship, but the other partner was unwilling or unable to invest the emotional energy. My theory incorporates systemic conditions (e.g. work load, staff shortages, and increased numbers of casual nurses) and contextual conditions (e.g. rapid patient turnover, acuity, and language barriers) as well as personal factors and interpersonal factors that influence participants’ decisions to step back from interactions with each other. More specifically, when
conditions and personal factors aligned to result in negative interpersonal dynamics nurses, patients, and family members were more likely to withdraw from each other or decide to stay at the focusing on tasks stage.

Although unilateral relationships can occur when patients are unresponsive (e.g. coma), Morse (1991) indicated nurses may be unwilling to invest in the relationship if they find the patient 'undesirable'. Depending on their attitudes toward the nurse and their illness and hospitalization, patients may respond to the nurses by being grateful, coercive, or manipulative or withdrawing altogether. My theory extends Morse's work, because, if negative personal dynamics were perceived as unbearable such as when one individual was abusive to another, it describes the potential for the nurse, patient, or family member to opt out of engaging altogether—an option not provided for in Morse's model.

My theory of progressively engaging also explained how nurses, patients, and family members made decisions to refrain from pursuing higher stages of engagement or to maintain the level of engagement already attained. When nurses regarded family members as unfriendly, uncooperative, or non-compliant with nursing care, the wishes of the patient, and/or hospital rules and routines and demanding or unrealistic in their expectations they were inclined to feel unappreciated and disrespected by the family. They were unwilling to invest time to get to know family members and the nurse-family relationship remained at a minimal level of engagement (focusing on tasks) or the family member(s) fell through the cracks. Similarly, when patients and family members perceived nurses to be too busy, unfriendly or 'business-like' and/or unhelpful in terms of providing information they described feeling like a number and were less inclined to get to know the nurse by asking questions or being friendly. These dynamics created cycles of
negative interpersonal dynamics that negatively affected patients' and family members' perceptions about nurses and nursing care, and nurses' job satisfaction.

6.6.3 Using questions.

My theory extends our understanding the processes participants use to manage their relationships, because asking and answering questions was a central and complex mode of nurse-patient and nurse-family interaction that influenced their efforts and/or willingness to engage with each other beyond focusing on tasks. Commentaries on the importance of information-sharing by nurses from the perspective of patients and families are abundant in the nursing literature. Bell (2004) emphasized families' "tremendous' need of support and information from nurses and the importance of nurses answering questions and concerns, and including families in information or assisting them to get information from physicians. In their examination of family members experiences in hospital, Astedt-Kurki, Paunonen, and Lehti (1997) found that families got the most support from information from nurses. My theory not only explains how patients and family members depend on information from nurses but also how they assign meaning to nurses' efforts and willingness to take time to answer their questions. They regard their responses as indicators of respect and caring for them.

In addition, my theory indicates that patients and family members were more likely to regard nurses who took time to answer their questions or provide information as competent and trustworthy. They would not engage with nurses they regarded as incompetent. Patients and family members felt more visible and more than 'just another patient in a bed' when nurses used questioning and responded to their questions. Through such acts as information sharing, patients and family members felt valued by nurses, which increased the likelihood of positive
interpersonal nurse-patient/family dynamics and their willingness to pursue higher stages of engaging.

A hallmark of the establishing rapport stage of engaging in my theory was the spontaneous sharing of information between nurses, patients, and family members that raised feelings around engagement to mutual comfort, security (trust), and caring, described by one patient as a 'deep human experience'. These findings support the work of Williams and Irurita (2004). They indicated that information-sharing by nurses was considered by patients to be a therapeutic interaction resulting in feelings of emotional comfort described as pleasant positive feelings and a state of relaxation, which, in turn, promoted a sense of feeling secure, informed, and valued. My theory extends Williams and Irurita's (2004) work, because they did not account for the perceptions of families and nurses or the effects of structural conditions on patient perceptions. My theory also accounted for the effects of a lack of information-sharing through questioning, which perpetuated lower levels of engaging and increased the risk that some patients and families would 'fall through the cracks'. Patients and family members associated 'falling through the cracks' with poorer satisfaction and health outcomes.

The theory of progressively engaging described the conditions associated with lack of questioning and information-sharing. Patients and families who perceived nurses to be 'too busy', unfriendly or business like, or failing to overcome language barriers on the part of the patient and family members were less inclined to ask questions or share information. Patients and family members also hesitated to ask questions of nurses that they did not know (casual nursing staff) or perceived to be less competent, by virtue of their observations of the nurse's care of their family member. My findings support Williams and Irurita's (2004) claims that insufficient information-sharing by nurses, as well as nurses' lack of availability, resulted in
patients' negative feelings and tension. My theory extends their work by describing how perceptions constrained nurses’, patients’ and family members’ willingness to engage beyond focusing on tasks or resulted in them stepping back.

Verhaeghe et al. (2005) claimed that, although family members of patients in the intensive care unit have a universal need for information, many nurses do not sufficiently appreciate the cognitive needs of families, consider providing information the doctor’s responsibility, and/or underestimate their own role in providing information about patient care. Astedt-Kurki, Paunonen, and Lehti (1997) reported that, unless patients and families took initiative to seek information from nurses, it was not forthcoming. They described types of information sought by patients and families as changes in the patient’s condition and explanations about treatment, equipment, the unit, and the staff. My theory extends our understanding by explaining the relationship between nurses’ “busyness” and managing their relationships with some patients and families by focusing on tasks. Those nurses were more likely to depend on patients and families to signal their need for information or assistance by asking questions, or ringing the call bell. Nurses in my study assumed that, if they did not ask questions, family members and patients were happy with the process. My findings offer some insight to Verhaeghe et al.’s (2005) claim that family members and patients may expect their needs to be met by nurses without having to ask.

In my theory of progressively engaging, questioning was not uniformly viewed positively. Stable patients and families were expected by nurses to use discretion around when they asked questions, take advantage of times the nurse was at the bedside, and make an effort to help themselves or their ill family member. Nurses also expected that patients and family members
would ‘observe the rules’ of the hospital. In contrast, Verhaeghe et al. (2005) argued that nurses generally underestimate families’ cognitive, emotional, social and practical needs.

Although my theory extends Verhaeghe et al.’s (2005) claims that nurses underestimate patient needs for information, it also describes conditions, which explain when nurses make extra efforts to use questions to respond to patients and family members, and how those responses influence interactive processes and the stage of engagement. Progressively engaging links nurses who manage their relationships by focusing on tasks and limiting their use of questions with perpetuating negative interpersonal dynamics. The theory supports Wright and Bell’s (2004) hypothesis that “the nature of interaction itself may possibly be more important than the specific information provided” (p. 6).

6.6.4 Reciprocity.

The importance of mutual respect to the development of positive nurse-patient and family member relationships in acute care hospital settings is highlighted by my theory of progressively engaging. Achieving higher levels of engagement in nurse-patient and nurse-family relationships was dependent on the degree of mutual trust and respect that developed between nurses and patients and nurses and family members in the course of providing care. The engagement trajectory captures the movement from getting a feel for each other, with tentative feelings of trust and respect, to pursuing establishing rapport with strong mutual trust and respect.

Other commentaries on reciprocity have emphasized the importance of mutual trust and respect, but have been embedded in therapeutic nurse-patient/family relationships or caring as a moral imperative (Lynn-McHale & Deatrick, 2000; Peter & Pauly Morgan, 2001; Wright & Leahey, 2005). Lynn-McHale and Deatrick (2000) described trust as a process based on mutual intention, reciprocity, and expectations. Fredriksson and Eriksson (2003) maintained that the
caring conversation between nurses and patients remains unsymmetrical, unless balanced by respect, responsibility, and reciprocity. In their thesis, reciprocity refers to a moral imperative to treat others like you would like to be treated from which self-respect and responsibility unfold; however, they argued nurses should act on the basis of duty to care without reciprocity (Fredriksson and Eriksson). Similarly, in their exploration of professional caring in nursing, Fitzgerald and Van Hooft (2000) concluded that nurse’s willingness and commitment to the good of the other before self and without expectation of reciprocity, represents love in nursing and extends beyond an ethic of care. In other family theories, reciprocity has been characterized as circular communication between systems in which information flows in both directions and influences subsequent actions of each system (Leahey & Harper-Jaques, 1996; Wright & Leahey, 2005), which is more reflective of my findings, because in my study nurses were not prepared to act ‘selflessly’, without expectation of reciprocity.

De Raeve (2002) maintained the nature of patients’ trust in the health care system and its representatives, such as nurses, requires a moral obligation to respond in a trustworthy way; nurses must care about patients, that is, develop attitudes of generosity, charity, and compassion towards patients. Although an ethic of caring for others places emphasis on nurturing and alleviating suffering, Peter and Pauly Mogan (2001) maintained that an ethic of justice is also relevant, because nurses also rely on rules, principles, and fairness when they are dividing their time between several patients. The establishing rapport stage of my theory advances our understanding about conditions, factors, and interpersonal dynamics, including reciprocal trust and respect, which facilitate engagement among nurses, family members, and patients at the highest stage on the trajectory. When nurses, patients, and family members work towards
reciprocal trust and respect they pursue personal connections, which are consistent with what nurses, patients, and family members described as 'doing the job with heart'.

The literature claims that health care professionals also need professional recognition, respect support and safety in their workplace (Morse, 1991; McQueen, 2000; Peter & Pauly Morgan, 2000). McQueen argued that, although nurses can achieve and maintain rapport with patients, the effort involved in doing so can lead to mental exhaustion in unsupportive working environments. Morse identified four mutual relationships between nurses and patients that develop in hospital including: clinical relationships, therapeutic relationships, connected relationships, and over-involved relationships. Of the four relationships, Morse identified that over-involved relationships, best characterized as affectionate, reciprocal, mutually trusting and supportive without expectation of reward, are typically considered 'dysfunctional' by administrators and nurses outside the relationship because it is believed that decisions tend to place patient's personal desires and goals ahead of treatment goals, as well as what is best for the family, other patients, staff, and the institution. Consequently, nurses do not tend to 'get involved' with patients. Morse's findings fit with those of other authors who warn of the dangers of not maintaining clear nurse-patient boundaries (Peter & Pauly Morgan, 2001). My theory characterizes gestures of recognition and support, which enhance the development of mutual trust and respect, as ways participants can connect without losing sight of boundaries. Showing respect and trust for each other yielded trust and respect and further gestures of mutual recognition and support, notwithstanding institutional and work constraints. In other words, nurses, patients, and family members were aware of other demands and their boundaries were flexible around incorporating increased demands associated with patient acuity. My theory describes how nurses were more inclined to provide information and bend rules and how patients
and family members were more likely to ‘cut the nurses some slack’ by being patient when nurses were busy with sicker patients.

My theory of progressively engaging includes the stage of establishing rapport; however, few nurse-patient or nurse-family member relationships reached that stage. Many participants described it as the ‘ideal’. They acknowledged that high workload, rapid patient turn-over, increased numbers of casual nurses, language barriers, and demanding patients and families affected efforts at engaging so that most nurse-patient and nurse-family member relationships remained at the lower stages of progressively engaging. The notion that engaging at a high level represents an ideal rather than a reality in practice supports Morse’s (1991) view that most commonly nurse-patient relationships are therapeutic relationships, emphasizing care for the patient as a patient and not as a person. Although this type of relationship may be represented as ideal by hospital administration (Morse, 1991), my theory links negative interpersonal dynamics, focusing on tasks, stepping back, and opting out to perceptions of negative health care outcomes for patients and families and job dissatisfaction among nurses.

My findings support the work of Ramos (1991) who found that, because of the increase in sicker patients and shorter hospital stays, of the three levels of involvement and impasse states she used to describe nurse-patient relationships, achievement of level three, the most intense level of attachment, characterized by reciprocity and mutuality, was rare. Ramos also link ‘ideal’ levels of engagement to better outcomes for all of the participants rather than to inappropriate relationships or loss of boundaries. When nurses and patients and families described their level of engagement as ‘doing the job with heart’ they were reflecting on a stage of engagement characterized by deeper exchanges of personal information, more frequent shared gestures of recognition and support, and higher levels of mutual respect and trust. Nurses anticipated
patients' and family members' needs, by spontaneously offering information, bending rules, and making time to acknowledge them. Patients and family members reciprocated by being more cooperative, helpful, and understanding about the other demands on nurses' time.

In the theory of progressively engaging, by participants' willingness to pursue higher levels of personal connection, nurses became strong advocates for promoting the well-being of patients and their family members; patients and family members also became advocates for nurses. Patients and family members expressed frustration and unhappiness about their perceptions of nurses' working conditions and other patients' and family members' poor treatment of nurses. My findings are consistent with Ramos' (1991) claim that nurses who achieved emotional reciprocity with patients regarded these relationships as effortless and more 'fun'; they were more motivated to spend time with patients and provided numerous instances of giving above and beyond 'norms'. Those nurses acted in the context of institutional constraints that made such relationships more difficult to attain (Ramos). Because Ramos' work is limited to the perceptions of nurses, my findings extend her work, by accounting for the conditions, factors, and interpersonal dynamics that include perspectives of patients and families. My findings link positive responses to structural conditions, personal factors and interpersonal dynamics by nurses, patients, and family members who are in relationship to nurses' perceptions of time as more elastic.

6.6.5 Shared responsibility.

Although strategies used by patients and family members that inhibit nurse-patient/family interaction have been reported in the literature (Hupcey, 1998; Morse, 1991), patients' and family members' responsibility for developing positive or negative interpersonal dynamics with nurses has been largely ignored. It is rare to suggest that nurse-patient and nurse-family member
relationships may be enhanced by patients and families becoming more mindful of the impact of their interactions. The responsibility for monitoring the effects of interactions has been assigned solely to nurses. Hupcey (1998) called for nurses to be more reflective of their practice and be more sensitive to the needs of families. Morse (1991) discussed the benefit of nurses examining their practice from a humanistic perspective, in an effort to shift the balance of commitment from self to patient.

My theory of progressively engaging provides the categories of stepping back and opting out to explain nurses' , patients', and family members' lack of willingness to persevere in their efforts to engage when their responses to conditions, personal factors, and especially interpersonal dynamics was consistently negative. Although patients and family members identified respect as an important factor in their willingness to engage with nurses, nurse participants were particularly distressed about what they perceived as a general lack of respect for nurses and nurses' work by patients, family members, hospital administration, and government. Other authors have discussed how nurses' efforts to interact with patients and families may be inhibited by administrators in hospitals that do not value nurse-patient and nurse-family communication needs (Bull & Jervis, 1995; Duhamel, 1995; Hannum Rose, Bowman & Kresevic, 2000; McQueen, 2000). The effects of disrespect by patients and families on nurses appear to have been ignored. By highlighting the importance of respect from the perspective of nurses, the theory of progressively engaging provides a basis for considering the effects of declining respect for nurses on their relationships with family members and patients. Lack of regard for nurses and nurses' work may influence patients' and family members' perceptions and nurses' expectations, which negatively influences the development of interpersonal dynamics so necessary to progressively engaging.
6.6.6 Social capital.

Although the concept of social capital particularly as it pertains to health is immature (Carlson & Chamberlain, 2003), it can be used as a lens that assists nurses to consider their interpersonal interactions and relationships not merely as acts of selfishness or utility (Carlson & Chamberlain; Looman & Lindeke, 2005). Kritsotakis and Gamarnikow (2003) emphasized that social capital is not a feature of individuals within a particular society, but a feature of social structure. Characteristics of high social capital in communities include high levels of generalized trust to other people and public institutions, and social structures that facilitate social interactions between people (Lindström, 2003; Putnam, 2000). Looman and Lindeke (2004) also emphasized that social capital includes norms of reciprocity and trustworthiness. Carlson and Chamberlain, in their synthesis of the literature, concluded that trust is a key component of social capital and holds the strongest correlation to health outcomes, although it requires further exploration.

My findings indicate when nurses managed their relationships with patients and families with a lack of willingness to pursue personal connections they contributed to patients’ and families’ perceptions of nurses as being untrustworthy. My findings also suggest that nurses who achieved higher stages of engaging with patients and family members and then took advantage of the patients’ and family members’ willingness to cut them some slack by making them wait eroded patients’ and family members’ trust in nurses and health care. Similarly, participants’ views of hospital administrations as failing to support nurses’ efforts to pursue personal connections by undervaluing communication and failing to address workload and staffing issues contributed to the their lack of trust in the health care system. Increased casual nurses in the nursing workforce was a condition that contributed to patients’ and family members’ decrease in confidence in
nurses and the health care system because they felt those nurses were more likely to undervalue and disrespect them.

6.7 Implications

From the substantive theory of progressively engaging that has emerged from this study I have identified several suggestions for modifying and/or advancing our understanding of how nurses', patients', and family members manage their relationships in acute medical/surgical hospital settings. In this next section, I discuss implications arising from the study as they pertain to nursing practice, nursing administration, and nursing education. I also present implications that pertain to nursing research and offer recommendations for future studies. Finally, I present my concluding statements in support of a relational lens from which to view ongoing nursing theory and practice development in the context of understanding and managing nurse, patient, and family member relationships as they develop in acute care hospital settings.

6.7.1 Implications for nursing practice.

My core variable of progressively engaging has many implications for the way we theorize about and more importantly practice family nursing in acute care hospital settings. Progressively engaging theory explains how nurses', patients', and family members' perceptions of structural conditions and personal factors contribute to or detract from shared meanings and perspectives that facilitate or constrain their efforts to manage their relationships at higher stages of engaging. Uncovering meanings that influence the actions of self and others, therefore, is of central importance to promoting efforts aimed at facilitating positive interpersonal dynamics between nurses and patients and/or family members. Consequently, a major consideration arising from this study is the critical need for medical/surgical nurses to commit to a more relational approach to the care of patients and their family.
Although most nurses, patients, and family member participants in my study perceived establishing rapport stage with the outcome of ‘doing the job with heart’ as the ideal relationship, few actually achieved this highest stage on the progressively engaging trajectory. Instead, most nurse-patient and nurse-family member relationships were limited to getting the job done. A contributing factor to this trend may be that some nurses working in acute medical and surgical hospital units are unaware of how their responses to structural conditions and personal factors influence the way they choose to manage their relationships with patients and family members. This lack of awareness can perpetuate nursing behaviors or actions (e.g. rules, routines, rituals, attitudes) that patients and families regard as disrespectful.

To reverse this trend, practicing nurses require more information about how their responses to structural conditions and personal factors influence their interactions with others and, in turn, contribute to the development of positive or negative interpersonal dynamics. Moreover, nurses can improve their working conditions by acknowledging that patients’ and family member’s perceptions of nurses and nursing actions affect how patients and family members choose to interact with nurses. Providing ongoing or regular nursing education updates (e.g. hospital in-service) featuring the theory of progressively engaging and theories about social capital more generally offer opportunities to enhance acute care nurses’ understanding about the value of developing nurse-patient and/or family relationships that extend beyond focusing on tasks. But more importantly, it can provide pragmatic and relevant explanations about the processes that facilitate or constrain nurses’, patients’, and family members’ efforts to engage at higher stages in acute care hospital settings. Knowledge based on empirical evidence derived from practice is likely to be regarded as more meaningful to nurses thereby enhancing their willingness to use the information in practice.
It may also be beneficial for nurses to work towards developing reflexive skills in their everyday practice by becoming more observant about their interactions with people and by critically examining their knowledge, experiences, and actions that arise as a result of these interactions (Hartrick Doane & Varcoe, 2005). The theory of progressively engaging provides opportunities for critical examination of actions by considering how actions are influenced by the meanings nurses attribute to social interactions, interactions with self, and the socio-cultural environment or context in which interactions occur. Nurses working in acute medical and surgical units may find that attending to how they respond to work conditions, as well as, personal factors and interpersonal dynamics can lead to increased insight and awareness about how these responses influence their nursing practice decisions (e.g. allocation of nursing time) and how they manage their relationships with patients and family members. Self-awareness of the choices nurses make when they engage with patients and families can assist them to identify the effects of their decisions on nurse-patient and/or family relationships and provide opportunities to learn from and, if necessary, modify their approach.

Progressively engaging can assist nurses to understand how patients’ and family members’ perceptions of conditions, factors, and interpersonal dynamics are influencing their actions and their responses to nurses, the environment, and their illness/hospitalization experiences. This awareness can enhance nurses’ view of patients and family members as people with unique perceptions of and responses to the world. Getting to know patients and family members as individuals and not simply as ‘another patient in the bed’ can improve nurses’ abilities to identify and respond to individual patient and/or family member information and/or care needs. As my theory of progressively engaging demonstrates, getting to know people promotes increased trust and respect (positive interpersonal dynamics) necessary to building more personal and satisfying
nurse-patient and/or nurse-family member connections that characterize ‘doing the job with heart’. This was linked to increased job satisfaction, improved health care outcomes, and a more positive hospital experience for patients as well as for family members.

Progressively engaging also emphasizes how patients and families contribute to the development of positive or negative interpersonal dynamics. This has implications for how nurses communicate and interact with patients and family members. By conveying interest and concern about patients’ and family members’ perceptions of structural conditions and personal factors related to their or their ill family member’s health/illness experience and hospitalization, nurses’ can honor their perspective, which as progressively engaging has highlighted contributes to the development of positive interpersonal dynamics. Moreover, nurses’ ability to identify and respond to individual patient/family member needs may be enhanced.

Clients of nurses in acute care medical and surgical settings might benefit from receiving more detailed information about nurses’ work and clearer written and/or verbal guidelines about how they can contribute to facilitating positive working relationships with nurses. Keeping patients and family members better informed may be of benefit to nurses, patients, and family members because, as indicated in this study, seeking to understand the other’s perspective and sharing information conveys a willingness to pursue more personal connections and facilitates the development of mutual trust and respect associated with higher levels of engaging. If patients and family members are better informed about nurses’ work, they may be more inclined to feel more welcome in the hospital setting and part of the team as opposed to ‘just another number’.

My theory of progressively engaging suggests that when patients and family members are more informed they are more likely to cooperate with nurses, comply with nursing care, take more
initiative to help themselves or their ill family member, and 'cut nurses more slack' when nurses are busier with sicker patients or other structural conditions beyond their control.

Progressively engaging emphasizes that getting to know each other requires that nurses, patients, and family members take time to pursue personal connections; and given that time is often limited in acute care hospital settings, nurses' perceptions of time have major implications for the development of nurse-patient/family relationships. For example, nurses who, despite their busyness, invested time to incorporate personal elements of their patients and/or family members in their care and believed that undertaking tasks with patients and families did not exclude getting to know them were more likely to achieve higher stages of engaging compared to those nurses who constrained their relationships with patients and families to focusing exclusively on tasks. That some nurses are willing to invest time in a way that facilitates getting to know their clients while other nurses perceive that they only have time to focus on tasks has implications for the need to inform nurses about ways to strive toward developing more personal connections with patients and family members as part of their everyday practice. Peer recognition strategies could be used to acknowledge and possibly reward those nurses who, despite their busyness, invest time in their relationships with patients and families and value these relationships as being equally important to promoting positive health outcomes as meeting the physical and/or medically delegated aspects of care. Such recognition could inspire other nurses to modify how they structure their time with patients and/or families. Forms of acknowledgement may include opportunities to mentor other nurses especially new staff members and/or be recommended as positive role models or preceptors for student nurses working on the unit. These nurses could lead discussion groups or in-service sessions for nursing staff and/or be invited to participate on nursing practice advisory or planning committees.
The study findings have implications for the importance of patients’ and family members’ feedback about their interactions with nurses during hospitalization. Mechanisms that provide opportunities for patients and family members to articulate their perceptions about their interactions with nurses may be beneficial in terms of acknowledging and encouraging interactions that facilitate positive interpersonal dynamics. Feedback about interactions perceived to contribute to negative interpersonal dynamics can also be useful in terms of increasing nurses’ awareness of how they are being perceived and providing opportunities to reflect about how their approach with patients and families can be modified. Feedback could take the form of customer satisfaction questionnaires. Likewise, nurses should be assisted and/or supported in their efforts to utilize therapeutic communication skills to provide feedback to patients and/or family members, particularly if doing so may clarify meanings and improve nurses’, patients’, and/or family members’ willingness and/or effort to contribute to positive interpersonal dynamics.

The study findings have implications for how nurses can facilitate positive interpersonal dynamics with patients and family members by making small efforts to acknowledge or get to know patients and/or their family members, being cheerful, friendly, and providing information and/or answering questions despite their busyness. Indeed, progressively engaging highlights that it is not necessarily what nurses do that makes a difference but how they do it that counts. In return, patients and families are more inclined to regard nurses as competent and trustworthy and reciprocate by being more tolerant of nurse busyness. Based on progressively engaging theory it can be concluded that investing time to develop positive interpersonal dynamics is not always time intensive. Because there are conditions, beyond nurses’ control, that constrain their time with some patients and family members, nursing interventions that include taking time to explain nursing time allocation decisions to patients and family members as well as honoring
commitments and promises made are of central importance in terms of developing or preserving positive interpersonal dynamics necessary to achieve higher stages of engaging.

Progressively engaging suggests that, because nurses understandably perceive sicker patients and their family to be in greater need of nursing care and support, they typically allocate more nursing time to these patients and manage their relationship with them by 'fast-tracking' the nurse-patient and/or family relationship to higher stages of engaging. Nurses may manage more stable patients at lower stages of engaging or step back from higher stages already attained. Moreover, the study findings also suggest that some nurses may expect that patients and family members understand the basis for nurses' time allocation decisions when in fact they may not. Other nurses may assume that such information is beyond the comprehension of patients and family members. The theory suggests ways nurses can educate patients and families about hospital environments and work flow and the importance of information exchange to developing positive nurse-patient/family relationships. Nurses can help promote shared meanings with patients and family members by explaining how and why they have to manage their time, clarifying expectations, encouraging and answering patients' and family members' questions, and discussing with patients and/or family members how they can participate in their own care, as well as ways that patients and family members can support nurses in their efforts to provide care.

The theory of progressively engaging suggests that, if patients and family members understand their role, rights, and responsibilities in the acute care hospital settings including the importance of asking questions, sharing information with nurses, observing hospital policies, and cooperating with nurses' efforts to provide care, the likelihood of developing positive nurse-patient/family member interpersonal dynamics increases. Patients and family members can be
helped to promote shared meanings with nurses by teaching them about asking questions and being sensitive to the timing of such questions. Nurses can facilitate question asking by patients and family members by assisting them with how to frame questions, conveying their expectations around timing of questions, and by responding to patient and family queries as fully and with as much time as possible. Because patients and/or family members may lack knowledge and/or experience with illness and hospitalization, nurses may need to take a more active role in assisting patients and families understand their roles and responsibilities around care while in hospital. This may include explaining what to do and how to behave in unfamiliar situations. As part of routine admission it could be beneficial for all patients and family members to also receive orientation literature (e.g. pamphlets) that explains specific communication/behavioral guidelines and expectations – including the importance of questions - that nurses could review with them a part of the routine admission procedure.

6.7.2 Implications for nursing administration.

Progressively engaging focuses attention on hospital administrators need to avoid underestimating or ignoring how nurses’, patients’, and family members’ perceptions of such structural conditions as staffing shortages, high workloads, and rapid patient turnover can negatively affect their efforts and/or willingness to engage in more meaningful relationships beyond just doing the job. Moreover, in light of nursing recruitment and retention challenges, hospitals can also no longer afford to ignore working conditions that contribute to decreased morale and job satisfaction among nurses disillusioned by an employer they perceive to be unsupportive of their desire and/or efforts to engage with patients and families on a more personal level. Administrators can use the theory to help nurses to invest more time in developing relationships with clients. For example, they can attend to conditions such as
workload relief and creating a climate that values relationality as essential to care. By examining nurse-patient ratios and acuity levels, incorporating nursing time for interaction with patients as well as with families into workload formulas, and ensuring adequate staffing, hospital administrators can ease what many nurses' perceive as a system-imposed, scheduled approach to providing care that constrains nurse-patient and/or family interaction. Moreover, such measures convey hospital administrators' valuing of and expectations about nurses' efforts to engage with patients and family members.

The findings of my study have highlighted that, although nurses' face many challenges in their efforts to engage with patients requiring acute care and their families beyond focusing on tasks, the situation is further compounded by the large numbers of 'alternate living care' (ALC) patients who are being housed on acute care units until they can be placed in more appropriate settings e.g. long term care facilities or hospices. These patients often do not require an acute level of nursing care, but remain highly dependent on nurses to meet their basic activities of daily living which consumes a lot of nursing time and energy. My theory of progressively engaging suggests that nurses, as well as many patients and family members, perceive these extra demands as resulting in nurses' feeling overworked or 'burned out' and underappreciated by the health care system. Hospital and nursing administrators can acknowledge these additional demands on nurses' work by staffing accordingly. If there is a lack of more appropriate facilities for patients requiring a chronic level of care, acute care hospital administrators can ensure the proper ratio of registered nurses and licensed practical nurses to meet the needs of the patient population on acute medical and surgical units. This would include securing and maintaining a sufficient human resource pool so that nursing staff who call in sick can be replaced.
My theory of progressively engaging has indicated that achievement of higher levels of engagement in nurse-patient and/or family relationships is unlikely when they have limited time together, because nurses’ work schedules or patterns (e.g. shift work and part-time or particularly casual nursing) place them on units for short periods of time. Nursing administrators can examine the growing trend in casual nurses, be it administratively driven as a measure to address nursing shortages, as a cost containment initiative, or nurse driven in an effort to obtain professional flexibility. Although there are several employment advantages (e.g. fewer costs for benefits) as well as personal advantages (e.g. schedule control and flexibility) in the context of progressively engaging, nurses, patients, and family members conveyed a strong message that large numbers of casual nurses may preclude opportunities for nurses, patients, and families to get to know each other, which in turn, negatively impacts patients’ and family members’ confidence and trust in nurses and erodes nurses’ social capital. To address growing concerns about the negative effects of increased casual staff on nurse, patient and/or family relationships, hospital administrators may need to consider alternate staffing models, such as the use of more unit specific casual nurses. By receiving unit specific orientation and being utilized on a regular basis, unit-specific casual nurses would be familiar and comfortable with unit layout and routines, patient population, and regular staff. Unit-specific casual nurses may experience increased confidence and efficiency, and an enhanced sense of belonging and commitment to the nursing team and clientele which in turn, has the potential to contribute to their willingness and/or perceived ability to pursue more personal connection with patients and family members.

Hospital administrators can support staff nurses by providing them with opportunities to reflect on their experiences, exchange ideas, and give feedback about how issues and concerns related to hospital policies and practices, unit layout or design, shifting patient populations, and
communication with other members of the health care team facilitate or constrain their efforts to engage with patients and family members. Administrators can provide opportunities for nurses to serve as patient and family advocates through encouraging feedback about how the hospital is supporting and/or facilitating the development of positive interpersonal dynamics between nurses, patients, and family members. Administrators can improve communication through regular information sharing sessions and nursing team meetings with nurses.

On a more macro level, hospital administrations can utilize feedback from nurses to lobby the government to provide budgets that ameliorate systemic conditions (e.g. high nursing workload, increasing patient acuity, rapid patient turn-over, the shortage of chronic care or community facilities for non-acute patients, and the increasing trend toward casual staff) in acute care medical and surgical units. Policies can support the value of nurses investing time and effort to pursue more personal connections so that nurse-patient and nurse-family relationships can achieve higher stages of progressively engaging where satisfaction in care given and received and more positive health outcomes are achieved. Nurse administrators can advocate for nurses' needs to move beyond just 'doing the job' by lobbying for changes to a system driven by cost-containment policy and practice initiatives, without consideration for poorer health care outcomes, erosion of social capital held by the nursing profession and the health care system in general, and declining nursing retention and recruitment.

6.7.3 Implications for nursing education.

My progressively engaging theory highlights the importance of educating for reflective nursing practice. Nursing faculty can focus their efforts to develop students’ abilities to critically reflect on their practice in order to increase their awareness about how their responses to others and the environment influence the way they choose to manage their relationships with patients
and families. They can incorporate information in the lectures about the effects of verbal and non-verbal communication on patients' and family members' interest in pursuing engagement with nurses. Through such learning activities as reflective clinical journaling and/or debriefing, students can increase their awareness about how their efforts to care for patients and family members are facilitated or constrained by structural conditions and personal factors in clinical practice settings. Opportunities for reflection can also enhance students' understanding of how patient's and family member's responses are also shaped and influenced by their perception of nurses and structural conditions. When nursing faculty provide students with opportunities to reflect on and discuss what they see in clinical practice, they facilitate students' efforts to develop self-awareness about how their practice is positively or negatively influenced by their observations of and interactions with staff nurses during clinical practice experiences. The acquisition of reflexive skills help guide students in self-exploration and promotes insight into what is meaningful to patients and families, as well as what is significant about the conditions and personal factors that shape health care encounters and influence willingness to pursue personal connections at higher levels of engaging. Equipped with reflexive skills students will be better prepared to anticipate, identify and intervene for the purpose of preventing the development of negative interpersonal dynamics that constrain nurse-patient and/or family relationships.

Nursing curricula can emphasize nurses' positions in society and the importance of maintaining a positive reputation and relationship with the public sector. By incorporating an introduction and exploration of concepts, such as social capital, in nursing courses designed to develop nursing leadership, professionalism, and therapeutic relationships with clients, students may link the social-relational aspect of health and their responsibilities associated with protecting
and preserving public trust in the nursing profession as a whole. Incorporating the study of social capital from a health perspective can help students gain insight into the behaviors of others and how people's actions are influenced by their interactions with others (Looman & Lindeke, 2004). This understanding may assist students in their efforts to consider their relationships with patients and families from the contexts in which they occur. Knowledge of social capital will sensitize nursing students to social structures, including trust and norms of reciprocity that enhance or constrain social interactions between people and, in turn, influence the level of trust people have in those social structures (Carlson & Chamberlain, 2003; Lindström, 2003).

Teaching/learning strategies could include opportunities to: expand students' knowledge about community programs available to patients and families, to observe or participate in professional and government committees whose mandate includes health and social policy development, to develop and implement or volunteer for an existing social health promotion program or activity, all of which can facilitate social/political awareness.

Since progressively engaging suggests that the public's trust in the nursing profession can be enhanced through such social activities as effective communication, learning activities should not only focus on providing a strong grounding in communication skill development, but also on how these skills can be applied for the purpose of facilitating shared meanings between themselves and their clients. Situating communication learning scenarios within a customer service, public relations and/or conflict management context that emphasizes the importance of trust and respect may be of some benefit in terms of preparing students for 'the real world'. Coursework should also include nursing leadership theory that emphasizes nursing policy development and implementation issues in order to enhance students' political savvy. Nurses can use this knowledge and skill to influence nursing policy and resource allocation to counteract
systemic conditions that, as highlighted by progressively engaging theory, negatively affect their efforts to engage beyond focusing on tasks and/or result in falling through the cracks leading to poorer health outcomes and nurse/client dissatisfaction.

Finally, progressively engaging informs our understanding about the centrality of developing trust and respect through forms of communication, such as chatting socially, sharing health and illness information, sharing personal information, acknowledging patients and families as individuals, keeping promises, smiling, and being friendly. Emphasis on these approaches can occur during nursing skill acquisition labs and/or nursing clinical or practicum experiences. These are the interactions and qualities that for patients and family members distinguish a nurse who is just doing their job from a nurse who is doing their job with heart. So, while nurse educators are required to ensure that students are technically competent to practice – that is they are equipped with the skills to attend to the physical body, nursing educators should continue to emphasize that how nurses interact with patients and families (e.g. their efforts toward acknowledging and respecting what patients and family members hold as meaningful and significant in their health and healing experiences) are pivotal to building positive interpersonal relationships and should be included as progress indicators for how nursing students’ clinical performance is evaluated.

With respect to continuing education initiatives, because a relational nursing approach is relatively new, many practicing nurses may lack theoretical grounding in relational approaches to care and reflexive skills. Hospital educators should support ongoing nursing education by offering workshops or in-services addressing topics such as how to establish meaningful relationships with patients and families, and developing reflexivity in practice. Practicing nurses should be given opportunities to reflect on their relationships with patients and families in a
supportive educative environment that facilitates reflection and awareness development about how structural conditions, personal factors, and interpersonal dynamics influence their decisions about how they manage their relationships with clients.

6.7.4 Implications for nursing research.

From this study it has become evident that nurse-patient/family relationships often fail to progress beyond the focusing on tasks stage of engaging because social norms or expectations held by each the nurse, patient and/or family member with regard to the other may be incongruent or incompatible. Hypothetically, if patients and family members were better informed about the work nurses do, how nursing time is allocated, the importance of asking questions, and given some guidance about how they can contribute to establishing positive working relationships, the outcomes may be enhanced willingness on nurses’, patients’, and families’ parts to manage their relationships with each other to achieve higher stages of engaging. Studying the effects of providing more information to patients and families about ways that they can contribute to building positive interpersonal dynamics with nurses could occur through quantitative methods looking at satisfaction with care and health outcomes and qualitative methods looking at processes to determine the utility of the education/orientation initiative. A randomized controlled trial whereby information is provided to one patient and family member group in an acute medical and/or surgical hospital unit and no information provided to the other group may prove beneficial. Predicted outcome measures might be based on the hypothesis that there would be a positive relationship between patients and family members being more informed about nurses’ work and ways in which they can contribute to positive interpersonal dynamics with nurses (the dependent variable), and nurses, patients and family members perceptions of more positive nurse-patient/family interpersonal dynamics
leading to an increase in nurse-patient and/or family relationships perceived to be consistent with the getting acquainted stage of engaging or higher (independent variable).

More research is required to understand the personal implications of increasing relational complexity due to the myriad of structural conditions, personal factors, and interpersonal dynamics. A study could test the hypotheses that nurses who believe that they lack the skills and/or personal, professional or agency resources and support necessary to prevent negative interpersonal dynamics or implement strategies to reverse these dynamics when they occur will be less likely to engage in relational practice. To my knowledge, there has been no instrument developed to measure relational practice for use in acute medical and surgical hospital settings. Because progressively engaging theory describes how nurses, patients, and family members assign meaning, make decisions, and act in relation to the other as well as how these responses facilitate or constrain their efforts and/or willingness to engage at progressively higher stages of engagement, the theory could provide the grounding for the development and testing of a tool (e.g. questionnaire) to measure relational practice in these settings. The development of such an instrument would be beneficial to a program of study aimed at furthering our understanding about how nurses, patients, and family members manage their relationships around care in medical and surgical units as well as other areas of acute care hospitals where nurses, patients, and families come interact around care.

My study findings suggest that many nurses continue to operate from the perspective that attending to tasks associated with physical and medically delegated patient care – a more objective measure of nursing care, is the primary work performance expectation of the employer, nursing administration, and/or the majority of nursing colleagues. The relationships among variables in my study suggest several research questions: How do hospital policies affect the way
nurses manage their relationships with patients and family members in acute medical/surgical settings? How do hospital administrators communicate with nurses such that the development of nurse-patient/family relationships beyond just doing the job is encouraged or discouraged? How can hospital administrators be more supportive of nurses’ efforts to pursue higher stages of engagement with patients and/or family members?

Building on this study, research initiatives using questionnaires and/or semi-structured interviews aimed at exploring the meanings that nurses, as well as administrators, attribute to specific structural conditions (e.g. casualization) may further our understanding about what nurses perceive as barriers in the work environment that constrain their desire and/or efforts to manage their relationships with patients and family members beyond ‘just doing the job’. Such studies may prove beneficial in terms of illuminating the kinds of support nurses think would be useful to help them counteract negative structural conditions, which in turn, could help to advance strategies for policy and structural change in acute care hospital settings.

A significant finding of this study was that most nurse, patient, and family member participants described engaging at the establishing rapport stage from an idealistic versus an experiential perspective. While progressively engaging describes how responses to conditions and factors can facilitate or constrain nurses’, patients’, and family members’ efforts to manage their relationships at higher stages of engaging, further research is needed to test how, by implementing changes in nurses working conditions, development of mutual trust and respect might be facilitated. This raises research questions, such as: How do nurses’ work schedules affect the development of nurse-patient and/or family member relationships? What modifications in nurses’ schedules create a more team-oriented approach to staffing?
Further studies are also needed to more fully explore the impact of casualization of the nursing work force on the development of nurse-patient/family relationships at higher levels of engaging. The study findings have suggested that many nurses, patients, and family members regard casualization – a growing trend in nursing - as interfering with developing relationships beyond focusing on tasks. The findings point to many questions around casualization that warrant further investigation particularly in terms of the effects of casual nurses on the development of nurse-patient and nurse-family relationships in acute care settings. Specific questions may include: How does casual status affect nurses’ perceptions about the importance of investing time to get to know patients and family members? How do casual nurses’ perceptions of structural conditions and personal factors affect how they manage their relationships with patients and/or family members in medical/surgical or other acute care hospital settings?

This dissertation has illuminated the need for additional research aimed developing the concepts of reciprocal trust and respect, particularly as they pertain to building rapport in nurse-patient and/or family relationships in acute medical and surgical hospital settings. As the findings of this study have suggested, nurses are more willing to pursue personal connections with patients and family members who treat them with respect and show appreciation for their efforts to go above and beyond focusing on tasks; nurses will step back or opt out of pursuing personal connections with clients who are perceived as disrespectful (e.g. demanding), uncooperative or non-compliant, and unappreciative. Research questions arising from these findings include: What are the effects of nurses’ expectations or demands for respect in return for services? How do nurses’ expectations for reciprocity fit with their education about an ethic of nursing care without expectations of reciprocity?
On a final note, while reflecting on the significance of progressively engaging theory, in my work as a clinical nursing instructor on an acute medical unit, I observed how my first year nursing students established relationships with their patients. During debriefing sessions with these students, I asked them to describe their relationships with patients. Based on my observations and their descriptions, it became apparent to me that these students had 'gotten to know' their patients very well in a short period of time (e.g. over the course of a four hour shift) and they could relay intimate details about the patient's life experiences, personal context, and health-illness beliefs. Students' perceptions of the nurse-patient relationships they developed included: "we developed a trusting relationship"; "I was able to build rapport with this patient"; "my patient told me that she appreciated the time I spent talking with her". It seemed to me that these students were naturally 'fast-tracking' their relationships with patients to the getting to know stage of progressively engaging and some were developing interpersonal relationships that would enhance the likelihood that they could progress to the establishing rapport stage. These observations have led me to questions including: How do nurse educators promote and/or support students' efforts to engage with patients and family members in the classroom and in the clinical setting; How do nurse educators nurture students to maintain their commitment to getting to know and establishing rapport with patients and with family members; How do nursing students perceive effects of structural (systemic and contextual) conditions and personal factor in the acute care practice settings - including their interactions with practicing nurses on getting to know their patients; and How do students' perceptions facilitate or constrain their willingness to manage their relationships with patients and family members beyond focusing on tasks? Studies could compare and contrast how nursing students at various stages of their education establish nurse-patient/family relationships as well as how students' efforts fit with those of practicing
registered nurses. Such research could result in important recommendations for undergraduate and graduate nursing education.

6.8 Limitations

While progressively engaging theory makes an important contribution to family nursing theory and may offer guidance for nursing practice in acute care medical and surgical hospital settings, there are limitations to the study findings. Of particular note is the homogenous nature of the sample in terms of the age and gender of the participants. Because all nurse participants were female, the findings may only be applicable to female nurses in acute medical-surgical hospital settings. Similarly, with one exception, all patients and family member participants were over the age of fifty years thereby limiting the applicability of findings to patients who comprise an older population. Extending the theory by incorporating the perspectives of male nurse participants as well as accounting for greater variability in patient and family member age would be desirable. As well, by studying a larger number of groups who are more likely to achieve higher levels of engaging by fast-tracking their relationships, understanding of the conditions and factors that contribute to this rapid movement to higher stages of engagement would be enhanced.

Other limitations of the findings are associated with the study design. First, with the exception of four dyads, the findings do not represent nurses, patients, and family members in relationship with each other. Thus, it would be important to extend the theory of progressively engaging by incorporating the perspectives of nurse, patient, and family member in dyadic or triadic relationships. Secondly, because the findings are constrained by setting - namely acute medical and surgical units in acute care hospitals - another way to extend the theory would be to study other nursing practice areas, such as pediatrics and mental health settings. Since the research
design did not accommodate the study of nurse-patient and/or family member relationships as they developed over time, longitudinal data collection could offer insights for developing the substantive theory of progressively engaging. Because my study excluded casual and part-time nursing staff, evidence of a growing trend toward casualization of the nursing workforce offers an opportunity to extend the theory of progressively engaging by studying the perspectives of this population of nurses.

Finally, some limitations of the study findings are specific to the nature of the substantive theory of progressively engaging. Specifically, it could be argued that the relational emphasis in progressively engaging reflects the predominantly female sample. That is to say that, because it has been argued that woman relate differently than men (Belenky, Clinchy, Goldberger, & Tarule, 1997), as a substantive relational theory, progressively engaging may be more applicable to women. As Belenky et al. maintained women’s thinking is typically characterized as being more “emotional, intuitive, and personal” compared to their male counterparts (p. 6). Efforts to examine the male perspective of how nurses, patients, and family members manage relationships more fully would be valuable to support the relational nature of the theory.

6.9 Conclusion

To conclude, my study findings support a relational approach to nursing practice with patients and families as centrally important to managing nurse-patient and/or nurse-family member relationships in acute medical and surgical hospital settings. Based on the unique contribution of the theory of progressively engaging theory to what a relational approach means to practice, I surmise that nursing must embrace an expanded relational view that accounts for and honors the complex interaction of nurses’, patients’, and family members’ positive or negative perceptions about structural conditions and personal factors and their effects on their willingness and/or
perceived ability to engage beyond simply focusing on tasks. Through incorporating an expanded view of relationality that includes an understanding of the theory of progressively engaging, nurses', patients', and family members' efforts to get better acquainted and build rapport can be facilitated. That process can improve health outcomes, increase patients' and family members' satisfaction with care received, and promote nurses' satisfaction in a job well done.

6.10 Chapter Summary

In this chapter, I provided a summary of the substantive theory of progressively engaging that emerged from the findings of this study. I discussed the contribution that progressively engaging makes to nursing theory especially in terms of advancing extant understandings about how nurses, patients, and families manage their relationships with each other in acute care hospital settings. In particular, I emphasized the unique contribution of the theory of progressively engaging to family nursing theory, because it was developed from data obtained from nurse, patient, and family member participants and the core variable reflects all of their concerns around managing relationships during the provision of care in acute care hospitals. I discussed the methodological contribution of the study by arguing that the study contributes to an interpretivist perspective of nurse-patient/family relationships by accounting for the social construction of participants' interpretations of reality in acute care medical/surgical hospital settings. I compared and contrasted key aspects of my theory with the literature and emphasized how it supports or extends existing empirical work concerning three primary challenges to implementing family nursing theory to practice. I presented implications for nursing practice, administration, education, and ongoing research based on my theory. Finally, I provided my conclusions from the study and a summary of the chapter.
BIBLIOGRAPHY


Burke, R. Hospital restructuring, workload, and nursing staff satisfaction and work experiences. *Health Care Manager*, 22(2), 99-107.


Appendix A

The University of British Columbia
Office of Research Services and Administration
Behavioural Research Ethics Board
Certificate of Approval
Appendix B
Fraser Health Authority
Clinical Investigation Committee
Research Approval Letter
MEMORANDUM

TO:  Ms. C. Segaric, Ph.D. Candidate, and  Dr. W. Hati of the School of Nursing, University of British Columbia  
     Director, Nursing/Patient Care, RCH  
     Director, Nursing/Patient Care, ERH  
     Head, Department of Family Practice, RCH  
     Head, Department of Family Practice, ERH  

FROM: Dr. M. Foulkes, Chairman  
       Clinical Investigation Committee  

DATE: 17 November 2003  

SUBJECT: CIC Protocol 2003-39  
The Nature of Relationships Among Nurses, Patients and Family Members in the Acute Care Hospital Setting: A Qualitative Study.  

1. The above-noted study was reviewed by the Clinical Investigation Committee on 03 November 2003, and it was APPROVED. This approval is subject to logistical plans being arranged with Nursing and Ward Managers. The Departments of Family Practice should also be aware. A formal UBC approval should be provided.  

2. The Consent requires some modification. There should be a statement that signature of the Consent does not waive any legal rights. Dr. M. Foulkes, Chairman CIC, should be the local reference for subjects' rights. There should be a witness signature block (which could be signed by the Investigator). "Dissertation" should be removed from the Consent and the Information Sheet because it has little meaning to most people.  

3. The Clinical Investigation Committee consists of: Chairman, Dr. M.R. Foulkes (Physician, Anesthesiologist, with a special interest in Medical Ethics); Dr. L. Meredith (Professor, Educator, Marketing Authority, Lay Member); Dr. M. Vince (Biochemist, Laboratory Scientist); Dr. I. Thordarson (Department of Emergency Medicine); and Mr. Ed Dillon, (Doctor of Pharmacy, Clinical Pharmacist to the Emergency Department, RCH). The Committee requests that you send a full financial report to the Vice President, Medical Affairs, detailing funds received and expenditures. This report will remain confidential information. You are also requested to inform the office of Administration, Royal Columbian Hospital, when the project has been completed, as well as forward any published material resulting from this study. Committee approval is not based on finite time but on the life-time of the project. Please submit requests for annual review, if this is required. Approval of the study includes approval of the locally generated consent form, unless otherwise stated. Copies of adverse event reports submitted to the investigator.
Appendix C
South Fraser Health Authority
Regional Research Review Committee
Research Approval Letter
APPENDIX D
Fraser Health Authority
Clinical Investigation Committee
Approval for Extension
Appendix E
Participant Information Letters
environment as well as personal beliefs and values affect interactions among nurses, patients and family members.

Criteria for Selection:

In order to qualify to participate in the study, you must meet the criteria outlined below:

If you are a patient eligible to participate in the study, you are:

- 19 years of age or older.
- Admitted to hospital for care and treatment of heart disease, lung disease, disease of the stomach, intestines or bowel, an accidental injury such as a fall or motor vehicle accident, or acute complications with diabetes or some other medical problem.
- Hospitalized for 24 hours or more.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

If you are a family member eligible to participate in the study, you are:

- 19 years of age or older.
- A person who is who is kin, friend, sharing living space, and/or bound by blood or marriage.
- A person available to provide support to the patient.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

If you are a Registered Nurse eligible to participate in the study you are:

- Registered in the province of British Colombia.
- Employed in a facility where wards are participating in the study.
- Assigned to the care of a patient who is eligible to participate in the study for a minimum of 8 (not necessarily consecutive) hours.

Study Procedures:

If you agree to participate in the research study, I will obtain your informed
consent and interview you at a mutually convenient time and private location within the hospital setting. The interview will take approximately one hour to complete. In addition, you may be requested to participate in a second shorter interview at another time. All interviews will be audio taped and the tapes will be transcribed for analysis.

During the interview, you will be asked to reflect on and describe a recent experience where you were either the nurse, the patient or a family member in an interaction directed at planning and providing nursing care. You will also be asked to comment on any factors associated with the hospital environment or personal beliefs and values held by any of the participants that affected the interaction. For reasons of confidentiality, you will be requested to not identify any of the other participants in the interaction by name.

I am also interested in observing interactions among nurses, patients and family members directed at planning and providing nursing care. Therefore, I may take advantage of an opportunity to observe your interaction with others (nurses, patients and/or family members) as it occurs within the hospital setting. While observing, I will not engage in the interaction but will keep a record of my observations. If at any time you wish to terminate an interview or observational experience I will do so immediately. If you feel uncomfortable about any of your comments on tape you may request to have the tape erased.

If you agree to participate in the initial interview, an observational experience, and a possible second shorter interview, you are being asked to devote between 2 to 3 non-consecutive hours in total to the study.

Benefits:

I believe that participants may gain a sense of satisfaction from knowing that they have made a valuable contribution to the development of nursing knowledge and family nursing practice that will be of benefit to other nurses, patients and family members. In addition, it may be personally beneficial to participants to describe particular incidents or experiences that they have had in interaction with nurses, patients and/or family members around planning and providing care as well as factors that may have helped, hindered or prevented such interactions in the acute care setting.

Confidentiality:

Any information as to the subject's identity resulting from participation in this research study will be kept strictly confidential. All documents will be identified.
environment as well as personal beliefs and values affect interactions among nurses, patients and family members.

Criteria for Selection:

In order to qualify to participate in the study, you must meet the criteria outlined below:

If you are a patient eligible to participate in the study, you are:

- 19 years of age or older.
- Admitted to hospital for care and treatment of heart disease, lung disease, disease of the stomach, intestines or bowel, an accidental injury such as a fall or motor vehicle accident, or acute complications with diabetes or some other medical problem.
- Hospitalized for 24 hours or more.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

If you are a family member eligible to participate in the study, you are:

- 19 years of age or older.
- A person who is one of the following: family, friend, sharing living space or related by blood or marriage.
- Available to provide support to the patient.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

If you are a Registered Nurse eligible to participate in the study you are:

- Registered in the province of British Colombia.
- Employed in a facility where wards are participating in the study.
- Assigned to the care of a patient who is eligible to participate in the study for a minimum of 8 (not necessarily consecutive) hours.

Study Procedures:

If you agree to participate in the research study, I will obtain your informed
consent and interview you at a mutually convenient time and private location within the hospital setting. The interview will take approximately one hour to complete. In addition, you may be requested to participate in a second shorter interview at another time. All interviews will be audio taped and the tapes will be transcribed for analysis.

During the interview, you will be asked to reflect on and describe a recent experience where you were either the nurse, the patient or a family member in an interaction directed at planning and providing nursing care. You will also be asked to comment on any factors associated with the hospital environment or personal beliefs and values held by any of the participants that affected the interaction. For reasons of confidentiality, you will be requested to not identify any of the other participants in the interaction by name.

I am also interested in observing interactions among nurses, patients and family members directed at planning and providing nursing care. Therefore, I may take advantage of an opportunity to observe your interaction with others (nurses, patients and/or family members) as it occurs within the hospital setting. While observing, I will not engage in the interaction but will keep a record of my observations. If at any time you wish to terminate an interview or observational experience I will do so immediately. If you feel uncomfortable about any of your comments on tape you may request to have the tape erased.

If you agree to participate in the initial interview, an observational experience, and a possible second shorter interview, you are being asked to devote between 2 to 3 non-consecutive hours in total to the study.

Benefits:

I believe that participants may gain a sense of satisfaction from knowing that they have made a valuable contribution to the development of nursing knowledge and family nursing practice that will be of benefit to other nurses, patients and family members. In addition, it may be personally beneficial to participants to describe particular incidents or experiences that they have had in interaction with nurses, patients and/or family members around planning and providing care as well as factors that may have helped, hindered or prevented such interactions in the acute care setting.

Confidentiality:

Any information as to the subject's identity resulting from participation in this research study will be kept strictly confidential. All documents will be identified Version: January 2004
Appendix F
Consent Forms
1. A patient who is:

- 19 years of age or older.
- Admitted to hospital for care and treatment of heart disease, lung
disease, disease of the stomach, intestines or bowel, an accidental injury
such as a fall or motor vehicle accident, or acute complications with
diabetes or some other medical problem.
- Hospitalized for 24 hours or more.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to
communicate.

2. A family members who is:

- 19 years of age or older.
- A person who is kin, friend, sharing living space, and/or bound by blood or
marriage.
- A person who is available to provide support to the patient.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to
communicate.

3. A Registered Nurse who is:

- Registered in the province of British Colombia.
- Employed in a facility where wards are participating in the study.
- Assigned to the care of a patient who is eligible to participate in the study
for a minimum of 8 (not necessarily consecutive) hours.

Study Procedures:

By giving your consent to participate in this study, you agree to be interviewed
by Cheryl Segaric, at a mutually convenient time and private location within the
hospital setting. You understand that the interview will take approximately one
hour to complete and that you may be requested to participate in a second
shorter interview at another time. You also understand that all interviews will be
audio taped and the tapes will be transcribed for analysis.

During the interview, you will be asked to reflect on and describe a recent
experience where you were either the nurse, the patient or a family member in
an interaction directed at planning and providing nursing care. You will also be
asked to comment on any factors associated with the hospital environment or personal beliefs and values held by any of the participants that affected the interaction. For reasons of confidentiality, you will be requested to not identify any of the other participants in the interaction by name.

In addition to the interview(s), you understand that Cheryl Segaric may observe your interactions with others (nurses, patients and/or family members) as it occurs within the hospital setting. While observing, Cheryl will not engage in the interaction but will keep a record of her observations. You understand that, if at any time you wish to terminate an interview or observational experience Cheryl will do so immediately upon request. If you feel uncomfortable about any of your comments on tape you may request to have the tape erased.

You understand that by participating in the initial interview, an observational experience, and a possible second shorter interview, you are being asked to devote between 2 to 3 non-consecutive hours in total to the study.

**Benefits:**

You understand that through your participation in the study, you may gain a sense of satisfaction from knowing that you are making a valuable contribution to the development of nursing knowledge and practice that will be of benefit to other nurses, patients and family members. In addition, it may be personally beneficial to you to describe particular incidents or experiences that you have had in interaction with nurses, patients and or family members around planning and providing care as well as factors that may have helped, hindered or prevented such interactions in the acute care setting.

**Confidentiality:**

You understand that any information as to your identity resulting from participation in this research study will be kept strictly confidential. All documents will be identified only by a code number and kept in a locked filing cabinet. You will not be identified by name on any reports of the completed study. The data records kept on the computer hard drive will be protected by an access password and the computer will be in a locked office. The University of British Columbia requires that all data be securely stored for 5 years following completion of the study after which time it will be destroyed.

**Consent:**

You understand that if you have any questions or desire further information with
respect to this study, you may contact, Cheryl Segaric at 604-461-1211.

You understand that if you have concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office of Research Services at 604-822-8598. You may also contact Dr. M Foulkes, Chairman of the Clinical Investigation Committee for the Fraser Health Authority, Simon Fraser Area at 604-520-4253, extension 4602.

You understand that your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without jeopardy to your care or the care of your family member in the hospital or in the case of nurse participants, without jeopardy to your employment at the hospital.

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

You understand that your signature indicates that you consent to participate in this study but does NOT waive any of your legal rights as a study participant.

<table>
<thead>
<tr>
<th>Subject Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Printed Name of the Subject signing above.

<table>
<thead>
<tr>
<th>Witness Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Printed Name of the Witness signing above.

Version: January 2004
1. A patient who is:

- 19 years of age or older.
- Admitted to hospital for care and treatment of heart disease, lung disease, disease of the stomach, intestines or bowel, an accidental injury such as a fall or motor vehicle accident, or acute complications with diabetes or some other medical problem.
- Hospitalized for 24 hours or more.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

2. A family member who is:

- 19 years of age or older.
- A person who is one of the following: family, friend, sharing living space or related by blood or marriage.
- Available to provide support to the patient.
- Able to speak and read English.
- Able to communicate with the researcher in an interview format.
- Without any physical or mental disabilities that affect your ability to communicate.

3. A Registered Nurse who is:

- Registered in the province of British Columbia.
- Employed in a facility where wards are participating in the study.
- Assigned to the care of a patient who is eligible to participate in the study for a minimum of 8 (not necessarily consecutive) hours.

Study Procedures:

By giving your consent to participate in this study, you agree to be interviewed by Cheryl Segaric, at a mutually convenient time and private location within the hospital setting. You understand that the interview will take approximately one hour to complete and that you may be requested to participate in a second shorter interview at another time. You also understand that all interviews will be audio taped and the tapes will be transcribed for analysis.

During the interview, you will be asked to reflect on and describe a recent experience where you were either the nurse, the patient or a family member in an interaction directed at planning and providing nursing care. You will also be
asked to comment on any factors associated with the hospital environment or personal beliefs and values held by any of the participants that affected the interaction. For reasons of confidentiality, you will be requested to not identify any of the other participants in the interaction by name.

In addition to the interview(s), you understand that Cheryl Segaric may observe your interactions with others (nurses, patients and/or family members) as it occurs within the hospital setting. While observing, Cheryl will not engage in the interaction but will keep a record of her observations. You understand that, if at any time you wish to terminate an interview or observational experience Cheryl will do so immediately upon request. If you feel uncomfortable about any of your comments on tape you may request to have the tape erased.

You understand that by participating in the initial interview, an observational experience, and a possible second shorter interview, you are being asked to devote between 2 to 3 non-consecutive hours in total to the study.

Benefits:

You understand that through your participation in the study, you may gain a sense of satisfaction from knowing that you are making a valuable contribution to the development of nursing knowledge and practice that will be of benefit to other nurses, patients and family members. In addition, it may be personally beneficial to you to describe particular incidents or experiences that you have had in interaction with nurses, patients and or family members around planning and providing care as well as factors that may have helped, hindered or prevented such interactions in the acute care setting.

Confidentiality:

You understand that any information as to your identity resulting from participation in this research study will be kept strictly confidential. All documents will be identified only by a code number and kept in a locked filing cabinet. You will not be identified by name on any reports of the completed study. The data records kept on the computer hard drive will be protected by an access password and the computer will be in a locked office. The University of British Columbia requires that all data be securely stored for 5 years following completion of the study after which time it will be destroyed.

Consent:

You understand that if you have any questions or desire further information with
Appendix G
Demographic Questionnaire for Nurse Participants
Demographic Questionnaire for use with Nurses

Please answer the following questions:

1. Gender: ___ male ___ female

2. Age:
   ___ 20-29 yrs
   ___ 30-39 years
   ___ 40-49 years
   ___ over 50 years

3. What is your cultural identity?
   ___ Aboriginal
   ___ African
   ___ American
   ___ Arab
   ___ Asian
   ___ Canadian
   ___ Caribbean
   ___ Chinese
   ___ European
   ___ Latin
   ___ Central or South American
   Other (explain) ___________________

4. Marital status:
   ___ married
   ___ single
   ___ other (please specify) ___________________

5. Number of children: _____ (please specify)

6. Number of years practicing as a Registered Nurse:
   ___ less than 1 year
   ___ 1-5 years
   ___ 5-10 years
   ___ 11-20 years
   ___ 21-30 years
   ___ more than 30 years
7. What is your job title? __________________

8. Employment status:
   ___ full-time
   ___ part-time
   ___ casual

9. Average number of hours worked per week? __________

10. Level of Education in Nursing:
    ___ Diploma in nursing
    ___ Baccalaureate degree in nursing
    ___ Master's degree in nursing
    ___ Specialty Certification (please specify) _______________________________
    ___ other (please specify) _____________________________________________

11. Non-nursing education:
    ___ Certificate
    ___ Diploma
    ___ Bachelors Degree
    ___ Masters
    ___ Ph.D
    ___ other (please specify) _____________________________________________

Version: July 2003
Appendix H
Demographic Questionnaire for Family Member Participants
Demographic Questionnaire for use with Family Members

Please answer the following questions:

1. Gender:   ___ male   ___ female

2. Age:      ___ 20-29 yrs
             ___ 30-39 years
             ___ 40-49 years
             ___ over 50 years

3. What is your cultural identity?
   ___Aboriginal
   ___African
   ___American
   ___Arab
   ___Asian
   ___Canadian
   ___Caribbean
   ___Chinese
   ___European
   ___Latin
   ___Central or South American
   Other (explain) __________________________

4. Marital status:
   ___married
   ___single
   ___other (please specify) __________________________

5. Number of children:      ___(please specify)

6. Relationship to patient: ______________________

7. What is your highest level of education?
   ___Elementary school (K-8)
   ___Some high school (9-12)
   ___High school completed
   ___Some college
   ___College completed
Demographic Questionnaire for use with Family Members (continued)

___ University courses
___ University degree
___ Post-graduate degree
___ Other (please specify)

8. Are you currently working? __________
9. If so, what is your job title? ______________
10. Average number of hours worked/ week ____________, /day ____________?
11. Have you missed any work due to the patients' illness? ______
12. If so, how approx. many hours /week ___________?

Version: July, 2003
Appendix I
Demographic Questionnaire for Patient Participants
Demographic Questionnaire for use with Patients

Please answer the following questions:

1. Gender: ___ male ___ female

2. Age: ___ 20-29 yrs
   ___ 30-39 years
   ___ 40-49 years
   ___ over 50 years

3. What is your cultural identity?
   ___ Aboriginal
   ___ African
   ___ American
   ___ Arab
   ___ Asian
   ___ Canadian
   ___ Caribbean
   ___ Chinese
   ___ European
   ___ Latin
   ___ Central or South American
   Other (explain) ____________________________

4. Marital status:
   ___ married
   ___ single
   ___ other (please specify) ________________________________

5. Number of children: ____ (please specify)

7. What is your highest level of education?
   ___ Elementary school (K-8)
   ___ Some high school (9-12)
   ___ High school completed
   ___ Some college
   ___ College completed
   ___ University courses
   ___ University degree
   ___ Post-graduate degree
   ___ Other (please specify) ________________________________
Demographic Questionnaire for use with Patients (continued)

8. Are you currently employed? _______

9. If so, what is your job title? ________________

10. Reason for hospitalization? ____________________________

11. How many days have you been in the hospital? _______

12. Is this the first hospitalization resulting from your current health concern?
   
   ____ yes
   
   ____ no

13. If no, how many previous hospitalizations have you experienced?
   (please explain)_________________________

14. Who do you consider to be your main support person or persons while you are hospitalized?
   
   Name:_________________________ Relationship:_________________________
   
   Name:_________________________ Relationship:_________________________

Version: July 2003
Appendix J
Initial Interview Guide for Use with Nurse Participants
Initial Interview Guide

For use with nurse participants:

Topic: Introduction of topic and identification of a recent example of how the nurse collaborated with a patient and the patient's family member(s) for the purpose of planning and providing care in the acute care setting. Endeavor to understand the significance and meaning of this process from the nurses' perspective.

1.0 Today we are talking about how nurses, patients, and family member(s) collaborate to plan and provide patient care in the acute care hospital setting. Perhaps you could start by describing a recent situation in which you collaborated with a patient and their family member(s) for the purpose of planning and providing patient care?

1.1 How did the collaborative process related to planning and providing patient care affect you as a nurse? (Probe for elaboration and meaning)

1.2 How do you think participating in a collaborative process to plan and provide care affected the patient? (Probe for elaboration and meaning from the nurse's perspective)

1.3 How do you think participating in a collaborative process to plan and provide care affected the patient's family member(s)? (Probe for elaboration and meaning from the nurse's perspective)

Topic: Identify from the nurse's perspective how (s)he and the patient and/or family member(s) collaborated to plan and implement patient care in the acute care hospital setting.

2.0 Did you work with patients and families to plan and implement care and if so, how?

2.1 Did the patient contribute to the process of collaboration, and if so, how?

2.2 What factors do you think affected the patient's ability or willingness to participate in the collaborative process? How did those factors affect the patient's ability to participate?

2.3 Do you think the family member(s) contributed to the process of collaboration and if so, how?

2.4 What factors do you think affected the family member(s) ability or willingness to participate in the collaborative process? How did those factors affect the family members' ability to participate?

Version: July 2003
2.5 Do you think you contributed to the process of collaboration and if so, how?

2.6 What factors do you think affected your ability or willingness to participate in the collaborative process? How did they affect you ability or willingness?

2.7 Who else, if anyone, had input into the collaborative process between the patient, family member(s) and yourself? (Probe to determine if the collaborative process involved the opinions or input of others such as other professionals, other family members or significant others and what that meant.)

Topic: Identify contextual and systemic features or structural conditions within the acute care hospital environment (e.g. within the hospital generally or the nursing unit specifically) that support or impede nurse/patient/family collaboration and decision-making around the planning and provision of patient care.

3.0 What factors here in the hospital setting do you think affected the process of collaboration between you, the patient and the family member(s)? How did they affect the process?

3.1 In your experience, how was the collaborative process between you, the patient and the family member(s) similar or different than those you have had with other patients and their family member(s)? (Probe for the purpose of encouraging reflection, contrast and comparison to promote researcher understanding about the influence of the environment on the process of collaborative decision-making from the perspective of the participant.)

Topic: Closure and provide opportunities for questions.

4.0 Is there anything else about the collaborative process between the nurse, patients’ and family member(s) that you would like to tell me about and feel you didn’t have the opportunity to?

4.1 Are there any questions in relation to what we have talked about today that you would like to ask me?

Thank you very much for your participation in the interview.

Version: July 2003
Appendix K
Initial Interview Guide for Use with Patient Participants
Initial Interview Guide

For use with patient participants:

Topic: Introduction of topic and identification of a recent example of how the nurse collaborated with a patient and the patient's family member(s) for the purpose of planning and providing care in the acute care setting. Endeavor to understand the significance and meaning of this process from the patient's perspective.

1.0 Today we are talking about how nurses, patients, and family member(s) collaborate to plan and provide patient care in the acute care hospital setting. Perhaps you could start by describing a recent situation in which a nurse worked with you and your family member(s) to plan and provide care?

1.1 Did the collaborative process related to planning and providing care affect you as the patient and if so, how? (Probe for elaboration and meaning.)

1.2 Do you think participating in a collaborative process to plan and provide care was important to the nurse and if so how?

1.3 Do you think participating in a collaborative process to plan and provide care was important to your family member(s) and if so, how? (Probe for elaboration and meaning from the patient's perspective.)

Topic: Identify from the patient's perspective how (s)he, the nurse and their family member(s) collaborated to plan and implement patient care in the acute care hospital setting.

2.0 Do you think the nurse contributed to the process of collaboration?

2.1 What factors do you think affected the nurses' ability or willingness to participate in the collaborative process? How did they affect her/his ability or willingness?

2.2 Do you think your family member(s) contributed to the process of collaboration and if so, how?

2.3 What factors do you think affected your family member(s) ability or willingness to participate in the collaborative process? How did they affect their ability or willingness?

2.4 Do you think you contributed to the process of collaboration and if so how?
2.5 What factors do you think affected your ability or willingness to participate in the collaborative process? How did they affect you ability or willingness?

2.6 Who else, if anyone, had input into the collaborative process between the nurse, your family member(s) and yourself? (Probe to determine if the collaborative process involved the opinions or input of others such as other professionals, other family members or significant others and what that meant.)

Topic: Identify contextual and systemic features or structural conditions within the acute care hospital environment (e.g. within the hospital generally or the nursing unit specifically) that support or impede nurse/patient/family collaboration and decision-making around the planning and provision of patient care.

3.0 What factors here in the hospital setting do you think affected the process of collaboration between you, the nurse and your family member(s)? How did they affect the process?

3.1 In your experience, how was the collaborative process between you, the nurse and your family member(s) similar or different than those you have had with other nurses and perhaps other family member(s)? (Probe for the purpose of encouraging reflection, contrast and comparison to promote researcher understanding about the influence of the environment on the process of collaborative decision-making from the perspective of the participant.)

Topic: Closure and provide opportunities for questions.

4.0 Is there anything else about the collaborative process between nurses, patients' and family member(s) that you would like to tell me about and feel you didn't have the opportunity to?

4.1 Are there any questions in relation to what we have talked about today that you would like to ask me?

Thank you very much for your participation in the interview.
Appendix L
Initial Interview Guide for Use with Family Participants
Initial Interview Guide

For use with family participants:

Topic: Introduction of topic and identification of a recent example of how the family member(s) collaborated with a nurse and the patient for the purpose of planning and providing care in the acute care setting. Endeavor to understand the significance and meaning of this process from the family member’s perspective.

1.0 Today we are talking about how nurses, patients, and family member(s) collaborate to plan and provide patient care in the acute care hospital setting. Perhaps you could start by describing a recent situation in which you worked with a nurse and your ill family member to plan and provide care?

1.1 Did the collaborative process related to planning and providing patient care affect you as the family member and if so, how? (Probe for elaboration and meaning.)

1.2 Do you think participating in a collaborative process to plan and provide care was important to your ill family member and if so, how? (Probe for elaboration and meaning from the family member’s perspective.)

1.3 Do you think participating in a collaborative process to plan and provide care was important to the nurse and if so, how? (Probe for elaboration and meaning from the family member’s perspective.)

Topic: Identify from the family member’s perspective how (s)he and the patient and nurse collaborated to plan and implement patient care in the acute care hospital setting.

2.0 Do you think your ill family member contributed to the process of collaboration and if so, how?

2.1 What factors do you think affected your ill family member’s ability or willingness to participate in the collaborative process? How did they affect his/her ability or willingness?

2.2 Do you think the nurse contributed to the process of collaboration and if so, how?

2.3 What factors do you think affected the nurses’ ability or willingness to participate in the collaborative process? How did they affect his/her ability or willingness?

2.4 Do you think you contributed to the process of collaboration and if so, how?
2.5 What factors do you think affected your ability or willingness to participate in the collaborative process? How did they affect your ability or willingness?

2.7 Who else, if anyone, had input into the collaborative process between the patient, the nurse and yourself? (Probe to determine if the collaborative process involved the opinions or input of others such as other professionals, other family members or significant others and what that meant.)

Topic: Identify contextual and systemic features or structural conditions within the acute care hospital environment (e.g. within the hospital generally or the nursing unit specifically) that support or impede nurse/patient/family collaboration and decision-making around the planning and provision of patient care.

3.0 What factors here in the hospital setting do you think affected the process of collaboration between you, your ill family member and the nurse? How did they affect the process?

3.1 In your experience, how was the collaborative process between you, your ill family member and the nurse similar or different than those you have had with other ill family members and nurses? (Probe for the purpose of encouraging reflection, contrast and comparison to promote researcher understanding about the influence of the environment on the process of collaborative decision-making from the perspective of the participant.)

Topic: Closure and provide opportunities for questions.

4.0 Is there anything else about the collaborative process between the nurse, patients and family member(s) that you would like to tell me about and feel you didn’t have the opportunity to?

4.1 Are there any questions in relation to what we have talked about today that you would like to ask me?

Thank you very much for your participation in the interview.
Appendix M
Participant Observation Guide
Participant Observation Guide

General description of characteristics and initial impressions of the nursing unit and staff:

1. What are the physical characteristics (size, smells, sounds, equipment) of the nursing unit?
2. What are my initial impressions (feelings) about the physical characteristics of the unit?
3. Is there anything that ‘stands out’ as being different than my expectations about the unit?
4. What other people are in the area and what are my observations about the characteristics of these people (appearance, title)?
5. What are my observations about what the people are doing?
6. What are my impressions about these people in relation to my presence?

Characteristics and initial impressions of the area where the participant observation took place (e.g. patient’s room) and others in the area:

1. What are the physical characteristics (size, smells, temperature, lighting, sounds, colors, furniture or equipment, privacy) of the area?
2. What are my initial impressions about the area?
3. Is there anything that stands out as different than my expectations about the area?
4. How might the physical layout support or interfere with the decision-making process between the nurse and patient?
5. What other people are in the area and what are my observations about the characteristics of these people (appearance, title, facial expressions and general body language)?
6. What are my observations about what the people are doing?
7. What are my impressions about these people in relation to my presence?

Observations and impressions of the nurse, the patient, family member(s):

1. What are the physical characteristics of the nurse including appearance, posture, facial expression, and body language?
2. What are my impressions about the nurse?
3. What are my impressions of the nurse’s response to my presence?
4. What are the physical characteristics of the patient including appearance, posture, facial expressions, general body language, aids used (equipment)?
5. What are my impressions of the patient?
6. What are my impressions of the patient’s response to my presence?
7. What family members are present?
8. What are the physical characteristics of the family member(s) including appearance, posture, facial expression and body language?
9. What are my impressions about the family member(s)?
10. What are my impressions about the family member’s response to my presence?

Observations and impressions of the nurse/patient/family interaction:
1. Does the nurse acknowledge the patient and if so, how?
2. Does the nurse acknowledge the family member(s) and if so, how?
3. What is the nurse doing?
4. Does the patient acknowledge the nurse and if so, how?
5. Does the patient acknowledge the family member(s) and if so, how?
6. What is the patient doing?
7. Does the family member(s) acknowledge the nurse and if so, how?
8. Does the family member(s) acknowledge the patient and if so, how?
9. What is the family member(s) doing?
10. Who initiates the interaction between the nurse/patient/family and how?
11. Where is the nurse positioned in relation to the patient and how does this seem to impact the interaction?
12. Where is the nurse positioned in relation to the family and how does this seem to impact the interaction?
13. Where is the family member(s) positioned in relation to the patient and how does this seem to impact the interaction?
14. Where is the researcher in relation to the nurse, patient and family member(s) and how does this seem to impact the interaction?
15. Describe the interaction including verbal and non-verbal behavior.
16. What are my impressions of the interaction between the nurse, patient and family member(s)?
17. How are my observations of the interaction different than my expectations?
18. Is there anyone else in the room/area and if so who and what are they doing?
19. How does the presence of other people seem to impact the interactions between the nurse, patient and family member(s)?
20. How does the presence of the researcher seem to impact the collaborative process between the nurse, patient and family member(s)?
21. If the nurse, patient and family member(s) have made a decision together related to the provision of care how do I know this based on my observation of their verbal and non-verbal interaction?
22. What are my impressions about the meaning that the decision has for the patient, family member(s) and the nurse, separately and collectively?
APPENDIX N
Sample Field Notes and Participant Observation Notes
The interview took place at xxx hospital on the medical unit North 51. The time was approximately 2:30 p.m. The staff nurse provided the patient with the information letter which she reviewed and stated that she would be interested in doing the interview. The patient requested to see me and to the interview right away.

The patient was in room one. It was a four-bed room and all beds were occupied. The patient was in bed D – close to the room entrance and across from the washroom. Curtains were drawn between each bed but not totally around each bed. When I entered the room the patient was lying on her bed on top of the covers. Her husband was sitting at the end of the bed even though there was a chair at the bedside. I introduced myself to both of them and shook the husband's hand. I was somewhat surprised by the way the patient looked. She appeared very pale and her eyes looked glossed over. She was trying very hard to engage in conversation, she seemed determined to participate in the interview even though it was clear to me that she was very ill. Her husband was very protective of her and I got the impression that he wasn't very keen on her doing the interview. He kept asking her if she was sure that she wanted to do this and reminding her that she didn't have to if she didn't want to. He also kept telling her that she could stop the interview whenever she wanted to. She continued to insist that she wanted to do it. She asked me what kind of questions I would be asking. She wanted to know how personal they would be and if they had anything to do with her illness because she wasn't sure how comfortable she would be talking about her current condition.

I reviewed the purpose of this study with both the patient and her husband. I also reviewed the conditions of consent including confidentiality, her right to refuse to answer any question, and her right to ask me to stop the interview at any time. I provided a copy of the consent form which she proceeded to read aloud in its entirety. She stated that she read it out loud for the benefit of her husband so that he would know what it was about. He then seems to relax a little and told her that he understood and was OK with her doing it if that is what she wanted to do. He then said that he had to go (when I first came into the room he mentioned that he had to leave in about 15 minutes). The couple then took a few minutes to say their goodbyes. I observed that they were very affectionate toward each other. I also noticed that there were many cards and flower arrangements at the patient's bedside. The flower arrangements had pretty much dried up. There were also several stuffed animals and a personal quilt was on the bed. I learned later that the patient had already been in the hospital for over three weeks.

When he left I stated that I hoped I hadn't scared him away. The patient said no he had to leave anyway. Before starting the interview I asked the patient if she would be more comfortable if I drew the curtain and she said yes. As I got up to draw the curtain I surveyed the area to determine the level of privacy that we would have. I observed that the other three patients in the room were sleeping. Throughout the interview we did not have any interruptions and the room remained relatively quiet with the exception of one time when he nurse came in to speak briefly to one of the other patients.

Throughout the interview the patient remained lying on her back. Her head was propped up with a pillow. Her feet were also elevated as she said she was trying to reduce some of the swelling. The patient did not appear to have any tubes such as intravenous, catheters, etc. Several times the patient interrupted the interview requesting that I pass her the water on her bedside table.
The patient seemed to understand my questions and responded appropriately to them. I did however get the impression that she did not understand the terms collaboration or interaction at least not from the context of the study. It seemed that interaction between nurses, patients, and family members meant conversation or the fact that they talked to each other. I also got the impression that it was important to her for me to know how much she appreciated nurses. She was extremely positive and appreciative of the care she had received while in the hospital.

**Observations:**

My observation of the nursing unit was that it generally appeared to be a very busy place. There were numerous hospital personnel around the nursing station. These included: unit clerks, nurses, CRN, nurse’s aides, speech therapist, a porter, and physicians. While some of the nurses were working 12 hour shifts, some were leaving after eight hours. I overheard two of the nurses saying that they were picking up additional patients at three o’clock. These nurses were discussing how many patients in the remaining hours of the shift required chemotherapy but it turned out there with only one patient and it was not the patient that they were assigned. All of the nurses that I spoke with were very pleasant and helpful. I met briefly with three RN’s to explain my study and seek their assistance with recruitment. They were very enthusiastic in terms of going over the patient list and determining who might be interested and who might qualify to participate in the study. They also did not hesitate to take information an information letter to the patient’s they identified. This process yielded two possibilities but only one actual interview. The nurses themselves seemed very reluctant to be interviewed. The CRN on the unit had thought one particular nurse would be interested and this nurse was present when I reviewed the information letter with them. She was very eager to know what kind of questions I would be asking and I provided a general idea stating that I was very interested in family nursing from their perspective. She declined to do the interview stating that she was involved in to many other things on the unit and didn't think she would be able to find the time.

**Observation notes**

September 12 and 26, 2004  
xxxxHospital – (medicine)

Each of these 4 nurse interviews took place on 2 west which is a medical unit at xxxx Hospital. According to the Patient Care Coordinator on the unit, the unit has 31 beds plus overflow and is a mix of medical and palliative patients. There is not a palliative unit in the hospital; consequently palliative patients are distributed within the medical and surgical areas of the hospital. Many of the patients on the medical unit are older, experiencing multiple system problems and are frequently disoriented. This nurse attributed the patient population as characteristic of the community demographics. She also stated that the nurses on the unit often experience multiple problems with families – they can be very demanding, even aggressive and it can be very frustrating for the nurses. The unit also deals with a lot of MRSA requiring that patients be on isolation precautions which impact nurse workload. The ratio of patients to nurse is generally 8:1. The nurses work 12 hour shifts and there are also LPN’s on duty. Although visiting hours are posted on the unit they are not enforced. There is a policy restricting numbers of visitors to two at one time – this policy is
enforced at the discretion of the staff depending on a variety of issues such as time of day, how many patients are in the room and how sick they are.

When I first came on to the unit it appeared dark and dingy; definitely in need of renovations. The nurses practice primary nursing however, the layout is such that they are split into teams based on the two corridors of patient rooms. The nursing station and utility-type rooms are located in the middle – the unit is shaped like the letter H with the nursing station in the middle. The nursing station was completely enclosed with a half wall and then glass to the ceiling. There were two doorways on either side for the HCW’s to come and go. The only access the public had was at a tiny window in front of the unit clerk’s desk. Even I found this quite intimidating standing there at the window waiting to be acknowledged by someone…anyone!

The hallways on this day contained many items such as linen carts and unused wheelchairs. On one side there were a couple of patients in recliners in the hallway as well. There seemed to be a lot of staff on. I saw several ‘nurses’ in the hallways, rooms and at the nursing station although I was not able to distinguish RN’s from LPN’s or other health care workers unless I occasionally got a good look at their name tag. The nursing station was a busy place most of the time I was there. There always seemed to be at least 2 physicians reading charts or making notes, several nurses charting, and nursing students. The phone seemed to ring constantly and/or there was someone standing at the window waiting for assistance. Sometimes it was the unit clerk who responded if the person happened to make eye contact with a nurse who just happened to be in the area she would inquire if she could help.

Browsing through one of the kardexes on the unit provided an overview of the variety of health care issues that patients on the unit had. Two of the patients on this day were considered palliative with diagnoses that included: CA uterus with mets and Paratoid CA with mets. The patients that were considered acute medical patients had diagnoses such as: # pelvis, resp failure, CA throat, pneumonia, abd pain and dehydration, lower resp. track infection, acute coronary syndrome, acute back pain. The age of the patients on the unit ranged from 35 years to 95 years. The mean age was approx. 75 years.

The nurses that I interviewed on this unit were identified to me by the unit manager as willing candidates. I believe that it was an expectation that certain nurses agree to be interviewed however, I did not get the impression that they did so grudgingly. Indeed, each nurse was very pleased to talk to me and signed the consent form without duress. Interviews were conducted on the unit in the small staff lounge. This room was basically a converted hospital room. It had one large window although not much light came through unless it was a very sunny day – which it wasn’t on the days that I was there. Even with a light on in the room it seemed very dim. There was a medium sized round table in the room with several chairs. There were small book shelves with various text and other resources, a refrigerator, microwave and places for nurses to put their personal items while on shift. There was a large bulletin board with pictures of various staff members and their family etc…

For each of the interviews the participants and I sat on angles facing each other with the tape recorder between us. I began each interview the same way: first by providing a brief over view of the study, then briefly reviewing the consent form followed by obtaining signed consent. The tape recorder was then turned on. With each interview I made sure that the door to the staff room was closed for privacy and to reduce the noise filtering in from the unit.
The day of this interview I was brought into the ICU by the unit manager to meet the nursing staff that was working. We gathered in the nursing station where I was introduced and allowed to give a quick overview of the study. The unit manager then asked specific nurses if they would be willing to allow me to interview them. One of the nurses was clearly uninterested – she was an older nurse and very set in her ways according to the others. I gathered that she followed a fairly rigid routine and didn’t want to disrupt that by taking time out to talk to me. A second nurse said that she would be willing and the unit manager made arrangements for her to be covered for 20 minutes or so. After the nurse had taken care of a few patient details she returned and we sat ourselves in a small room just off the nursing station. It was a nursing lounge and it was furnished with two soft couches and a coffee table in the middle. There was also a television, microwave and other such items for the nurses’ use. The set up wasn’t ideal for an interview simply because it was hard to position the tape recorder so that it would easily pick up both voices – especially when the participant sat back into the couch and away from the table. I stressed the importance of talking loudly enough so that the microphone could pick up the voices but this didn’t always work. The door to the room stayed open so that the nurse could monitor what was going on by the sounds coming from the unit – especially call bells and telephones ringing. It was evident that while she was willing to talk to me she also had one eye on what was happening on the unit. There were only 3 nurses on that day and I think she felt guilty about the others covering her. I tried to be sensitive to this and made an effort to be as efficient as possible with my questions – which also didn’t always work. Throughout the interview we had a number of interruptions. If the phone rang too long the nurse would get up and answer it; if the call bells seemed to be going unanswered she would get up to answer those as well. At one point a doctor came in to inquire about a patient that happened to be hers so she left for a few moments to deal with that. The unit wasn’t particularly busy in terms of numbers of patients but they were short staffed by one nurse so everyone’s load was increased. They also were preparing to transfer a patient to another hospital which meant one of the nurses would have to leave to accompany them in the ambulance and arrangements for back-up staff were being made. In addition to this, the older nurse was being very vocal about making sure each nurse took their entitled breaks. Despite the various interruptions the interview went fairly well. The nurse was young and had recently completed her training in critical care. Part of the course work she did included a family theory course so she was familiar with some of the concepts associated with family nursing practice. She made several comments about the lack of fit between theory and practice and this certainly set the context for some of the observations and opinions she shared with me. She was well informed and articulate. The interview ended up going longer than I had planned – this was not only due to the interruptions but also because of my lack of experience and/or eagerness to learn as much from her as I could. I considered her to be a good resource so I probably asked more questions than I should have. Fortunately she was very gracious but there clearly reached a time when
termination of the interview was required as I sensed she was getting anxious about being away from the unit too long. I thanked her for her time. She declined an executive report.

Fieldnotes – September 9, 2004
P-05, xxx Hospital – TCU

The interview took place in a small office on the unit that belonged to the patient care coordinator. The RN approached the patient on my behalf and asked if she was interested in talking to me. She agreed and walked from her room to the office to meet me. It turned out to be the same woman that I had observed earlier inquiring about her inhalation medications at the nursing station. She was tall and thin, had short grey hair and deep wrinkles in her face. She was approx. 67 years old but looked much older. Her gait was slow and she pulled an oxygen tank behind her. She had O2 infusing via nasal prongs.

We introduced ourselves to each other and both sat in chairs on opposite sides of the small desk in the Patient Care Coordinator’s office...The office was very small and had no windows. The participant positioned a portable oxygen tank beside her and adjusted the oxygen tubing and nasal prongs that she was wearing. Before leaving us the PCC told the patient to let her know if she needed anything and reassured her that I wouldn’t make her nervous. Earlier I had been told by the PCC that the patient’s breathing tends to become more labored with increased anxiety. The patient stated that she “would be fine”. The door was closed so we had complete privacy and there were no interruptions at any time throughout the duration of the interview.

Throughout the interview I found her [the patient] to be very alert and articulate despite the fact that she was evidently experiencing some difficulty breathing. She was doing what she called “controlled breathing” – slow, steady breaths in through her nose and out through her mouth. She took her time answering questions (due to the difficulty she experienced breathing and talking at the same time) but she had a good level of understanding; took time to critically reflect on the questions before answering, and did not hesitate to ask for clarification if she did not understand a question posed to her.

Prior to starting the interview the patient participant stated that she understood what the study was about and signed the consent form to participate. The interview lasted approximately one hour and progressed comfortably. I felt as though we were able to build a rapport quickly and she seemed comfortable sharing her illness experience with me. She also confided in me about the death of her daughter 13 years ago as well as discussed her current relationship with her other daughter. She disclosed that she had not discussed her feelings regarding her living daughter with the unit nurses so I considered this privileged information and reflective of the trust she had with regard to me and my role in that I was able to take the time to sit and listen to what she had to say.

At several points throughout the interview she became tearful. One time was when she discussed the death of her first daughter. At that moment I reassured her that it was o.k. that she cried and offered her a Kleenex. Another time that she cried was when she described her experience of living with what she referred to as the “silent disease”. She said that her friends did not understand how she suffered and would give her a hard time about ‘just being out of breath’. She stated that she liked being in the hospital because the nurses understood how sick she was and were very supportive.

By the end of the interview it was becoming obvious that she was starting to get tired. She took longer to answer questions and was doing more controlled breathing than previously. I began to
feel a sense of urgency to wrap it up and let her go back to her room to rest. She expressed that she was happy to have participated in the interview and hoped that it was helpful to me. She was very supportive of nurses in general saying that they are all totally overworked and underpaid and hoped that the health care system would improve soon. She was able to walk back to her room unassisted.

Fieldnotes – June 24, 2005
F-10, xxx Hospital

This interview took place in the nurses conference room located just behind the nursing station on 3B. It is a small conference room with a large sliding glass door so that the unit is visible to those in the conference room and vice versa. The family member was approached by the PCC on the unit and asked if she would be willing to participate in the study. The family member, who was the daughter of the patient, was extremely willing and she and her sister waited for me to arrive on the unit to conduct the interview. When I arrived I entered the patient’s room – the patient was in the second and middle bed of three in the room. The patient appeared to be sleeping and the two sisters were sitting in chairs up against the wall watching their mother and chatting quietly with each other. As I came in they seemed to recognize who I was right away. The one sister said “have you come to interview me?” I said yes and introduced myself. The patient began to stir and right away the other sister jumped up to attend to her mother while the other sister began to lead me out of the room. She indicated that she was free to talk to me and that her sister would take care of whatever their mother needed. The conference room was directly across from the patient room and was not being used at that time so we took advantage of this and went in. I closed the door to the room and although everyone could see us we had complete quiet and privacy for the duration of the interview (about 45 – 60 minutes).

I began by providing the usual description of the study and reviewed the information letter with the family member. I then talked about the need for the interview to be recorded and reviewed the consent form which the participant signed without hesitation. She seemed very enthusiastic and eager to participate right from the very beginning...I sensed she had some things on her mind that she wanted to tell me! Although we sat across from each other we both leaned forward with a level of curiosity and interest.

The interview flowed easily. I sensed almost immediately that we were comfortable with one another and this was confirmed by the fact that the participant used our interaction and the nonverbal communication between us as a comparison to some of the interactions she had with other nurses. Eye contact for example seemed very important to her – we had eye contact and this for her helped establish a positive trusting rapport.

The participant was of Asian descent and it was clear that English was not her first language. Consequently there were some questions that she did not understand at first however, she did not hesitate to ask for clarification and she was persistent in her effort to understand what I was asking. As a result we had little difficulty understanding one another but it served as a good example of how communication might be challenging if one did not take the time to ensure that mutual understanding was attained -this, as it turned out, was part of her message – part of what she wanted nurses to understand. Taking time to communicate was one way that nurses used their ‘heart’ as opposed to just doing their job.
Throughout the interview I was struck by her enthusiasm and her energy. She came across as a very caring and personable individual. As long as she understood my question she was comfortable taking the lead and responded with a great deal of detail. At one point it was disclosed that she was well over 50 years old. This came as a shock to me because she looked significantly younger although the wisdom and maturity evident in the way she handled herself and responded to my questions was evidence of her experience.

The interview lasted approximately 1 hour and it could have gone on longer. The participant was showing no sign of fatigue and probably would have talked and talked. She maintained her enthusiasm for our discussion right to the end and thanked me for the opportunity to express her views. I of course thanked her and told her how much I appreciated her many insights and her willingness to share them with me. It was a very positive and productive interview overall.

**Field notes - May 4, 2005**

**N-016, xxx Hospital Medical unit 3D**

I arrived on the unit at approx. 1330h with the intention of introducing myself to the PCC for the unit. The unit appeared quiet and I was greeted immediately by the unit clerk who indicated that the PCC had just been on the unit and she proceeded to go and look for her. In the meantime a nurse, who overheard my query stated that she thought the PCC was on her way to a meeting. A third nurse came along and asked if she could help me. When I indicated who I was looking for she immediately went off looking for the PCC as well. Moments later she returned with the Unit manager who informed me that the PCC was indeed gone to a meeting. The unit manager knew about the study could be of assistance. She introduced the RN who had gone and found her to me and began explaining the reason I was on the unit. I began to explain that I was hoping to interview patients, family members and/or nurses but especially family members and nurses. The unit manager explained to the RN that I was not allowed to approach patients directly and asked if there was anyone that she thought might be interested in talking to me. The RN pondered the question for a moment and I went on to say that I was very interested in talking to some nurses because there was some ideas that I wanted to verify with them. The RN then stated that she would be willing and that she had a bit of time at that moment. I informed her that it would take about 15-20 minutes and she agreed but first she had to “change a patient”.

I was brought into the small conference room at the nurses’ station to wait until the RN was free. The conference room had a glass front so we could see what was going on in the unit. It had one small round table with 6 chairs and a couple of filing cabinets.

When the RN returned we went over the information letter, the consent and she completed the demographic data sheet. She was not bothered by the tape recorder in the least and indicated that she had participated in studies in the past. Her demographic data sheet indicated that she had between 10-20 years of nursing experience but I could tell just by her demeanor that she was a seasoned RN. She was very relaxed and confident – we seemed immediately comfortable with each other and with the interview process. The interview progressed fairly easily although she had a tendency to resort to specific clinical examples and tended to steer off course a bit. However, she was easily drawn back to the questions at hand. She had no difficulty understanding the questions I asked and her responses were quite articulate, honest and thoughtful. The examples she provided made it clear that she drew on a lot of personal experience in relation to how she interacts and collaborates with others. She also presented as very passionate about her patients and about her job in general. She indicated that she was
involved in collaborative efforts with the hospital to improve nursing care and expressed concern that she did not feel that nurses had enough input into patient care especially with regard to long-term and discharge planning.

There were only two interruptions during the interview – when people came into the room to get things e.g. a book. Other than that we had a good degree of privacy. Because we could see out the glass windows and sliding door onto the unit, the RN did have her eye on what was going on outside the room just in case she was needed. The interview lasted approx. 20 minutes.

At the end I felt we had established a good rapport and she agreed to assist me the next day to identify some patients and family members who might be interested in participating in the study.

Fieldnotes – May 31, 2005
F-008, xxx Hospital

This interview took place on one of the medical units at xxx Hospital. The PCC of the unit had previously asked the patient’s wife if she would be interested in talking to me about the study and she indicated to her that she would. When I arrived on the unit I went into the patient’s room and introduced myself to the patient and his wife with the intention of obtaining consent and conducting the interview. I began by confirming her interest in speaking with me about the study and when she said she was willing I looked around for a place to sit. There was not an extra chair available in the room so I went out into the hallway and found a chair, brought it into the patient room and placed it beside the bed directly across from the family member and facing the patient. It was a semi-private room and the patient was the second bed away from the door. There was another patient in the first bed but he did not appear to be very alert at the time. I drew the curtain between the two patients which then provided complete (visual) privacy. It was very quiet in the room – there were no other visitors and little of what was going on outside the room could be heard from where we were seated.

I then provided a brief description of the study and right away the wife began telling me about her experiences in the hospital. I told her that in order to participate in the study she would have to agree to be audio taped and this made her a little nervous. Once again she began telling me about various exchanges she had had with the nurses and again I had to stop her to explain that I needed her to sign the consent and allow me to put the tape recorder on. The patient who was a bit confused overheard me talking about the need to ‘sign something’ and he began warning his wife not to sign anything stating that “she could be signing away their life savings!” The wife reassured him that everything was okay and I once again explained the purpose of signing the consent form.

Finally the family member signed the consent form and I placed the tape recorder on a bedside table placed between us and began the interview. The wife was very animated in her verbal and nonverbal expression and articulated her thoughts and feelings well throughout the interview. I got the impression that she was a going concern – very alert and active for her age – and she clearly was in charge of taking care of her husband’s needs and general well-being. The patients also struck me as being very ‘feisty’ despite his physical illness and his confusion. He took in bits of conversation and responded to what was being discussed. For example, at one point when his wife was discussing the fact that he was being transferred to another unit so that he could take advantage of more physiotherapy he stated that he didn’t need any more therapy and wanted to go home. The wife responded to him by saying that he needed to be stronger before he could go home to which he responded by shaking his fists and flexing his muscles and saying he was
strong enough and was going to leave. This exchange went on for a few more minutes until the wife was able to convince him that he needed to get a bit stronger and that he couldn’t go home until the doctor said it was okay. She then confided in me that she needed to make sure that he was strong enough before she took him home because she was not able to care for him otherwise. The interview progressed fairly well although it was clear to me that the family members was being careful not to be too negative in relation to the nurses. When she was expressing an opinion that was critical of a nurse she tended to lower her voice apparently so that others could not overhear what she was saying. Occasionally she became distracted by her husband if he became restless or of course when he decided to ‘participate’ in the conversation. She also remembered that her parking meter was running out during the interview so that was clearly on her mind as well. Such distractions did interrupt the flow of the interview but overall we were able to stay on track and she was comfortable with picking up where she left off with minimal prompt.

Participant Observation:
At one point during the interview the physiotherapist came around the curtain and greeted the patient. She began scolding the patient in jest because he refused to go to his therapy session earlier that day. It was clear that this communication was intended for the wife to let her know that he did not have his therapy and why. This prompted numerous questions from the wife which were directed a both the husband and the therapist and intended to flush out the reason why he refused. It was obvious by the way the three of them were interacting that there was a rapport that had been established. They clearly recognized one another so introductions were not necessary. It was also clear that the therapist acknowledged the family member was actively involved in monitoring her husbands’ care and progress. The therapist’s communication was intended to provide her with an updated report. This interaction prompted the wife to tell the therapist about the concerns she had about her husband’s foot. She went on to tell her that she had informed the nurses quite some time ago but they had not responded to that point. The therapist assured her that she would look into it and by the look on the wife’s face it was evident that she felt confident and relieved that something would be done. At no time during this exchange did the therapist acknowledge me until just as she was about to leave she noticed the tape recorder. At that point she asked if she was interrupting anything and apologized saying “oh, I thought you were just a visitor”.

At that point the wife again realized that the parking meter had probably run out by then and she needed to leave which promptly ended the interview.
APPENDIX O
Sample Conceptual Diagrams
Progressive Engagement
In the acute care hospital context
Progressive Engagement:
Process of ‘Getting to Know’

"Just doing the job" vs.
"doing the job with heart"
Nurse, patient and family relationships:

Terms of Engagement

Stage 1: Focusing on Tasks
- No interaction
- Feeling each Other out
  - ve interpersonal dynamics
  + ve interpersonal dynamics

Stage 2: Getting Acquainted
- ve interpersonal dynamics
+ ve interpersonal dynamics

Stage 3: Building rapport

Progressively Engaging

Doing the job with heart

Just doing the job.

Fall through the cracks

Opt Out

Step Back

Step Back

Step Back
Nurse, patient and family relationships:

Progressively Engaging

Just doing the job

Stage 1: Focusing on Tasks
-ve terms of engagement

Step Back

Opt Out

Stage 1: Getting Acquainted
-ve interpersonal dynamics

Stage 1: Building Rapport

Doing the Job With Heart

-ve interpersonal dynamics

+ve interpersonal dynamics

Stage 1: Focusing on Tasks
+ve terms of engagement

Fall through the cracks
Feeling each other out
Fall through the cracks

-ve interpersonal dynamics
+ve interpersonal dynamics

-ve interpersonal dynamics
+ve interpersonal dynamics

-ve interpersonal dynamics
+ve interpersonal dynamics

-ve interpersonal dynamics
+ve interpersonal dynamics
APPENDIX P
Sample Memos
Memos – Set One – May 2004
Re: P-002/F-001

?: There seems to be many examples that indicated uncertainty about who was who within the hospital or an inability to distinguish between nurses and other healthcare workers

The Impact of social forces: there seemed to be some issues or impressions about how the strike may have impacted them, patients in general, the hospital, the nurses…

It sounded as though there was a discrepancy between what the couple expected in terms of how the hospital would be affected by the strike (e.g. busier) and what they observed (not busy).

Expectations as they relate to acuity: Wife seemed to suggest that the level of expectations regarding nurse family interaction may depend on the circumstances around the hospitalization, the procedure done, and/or the condition of the patient. If the patient is more seriously ill then perhaps the nurses would interact/collaborate with the family more. The fact that her husband surgery was considered ‘elective’, ‘non-emergency’, ‘planned’ may mean that his need for nursing care is less. This possibly translates to the nurses not spending as much time with him and/or family members as compared to other patients on the unit or patient’s on the unit in general assuming they are there for mostly elective or pre-planned type surgeries.

Information sharing leads to increased trust:
*Telling what to do; what to expect.
*Good at explaining
*While doing checks the nurse also used the opportunity to explain, prepare, encourage. This way of interacting (?) seemed different to the pt. and family member than what they experienced with other nurses. They seem to have trusted this nurse more than the ‘on-call’ nurse.

NOTE: should have followed up on this difference more!

Getting to know:
Distinguishing once again between nurses who work ‘regularly’ vs. those who work ‘on-call’. The nurses on call don’t really know who you are and treat you more like just a patient in a bed. The regular nurses “get used to you”.

(?) The family member is suggesting that there is a relationship between length of stay and the seriousness of the illness/surgery affects how or if nurses collaborate.

(?) Nurses may also not see a need to collaborate (or it may not be high on their list of priorities) because they think patients and family members have already been informed by others e.g. Doctor

Professionalism/personality: Some nurses are more personable than others…
Some nurses just do their job; say what they have to say… “they have to be professional first”.

Does being professional relate to giving physical care only? How is the wife differentiating being professional and collaborating with patients and family members?

Interacting based on need (?) : Quite a few nurses at the desk; not that many patients; nurses didn’t come down much. Does this suggest that the nurses only interact with patients/family when they have to?

Business: the impression that nurses are busy may lead to the reluctance of pts/family members to ‘bother them’. It may also discourage interaction or ‘conversation’ about anything other than really important matters (e.g. physical care?). Perhaps this is why pt’s family members expect they will be approached if it is important…otherwise everything must be ok.
Patient never felt rushed by nurses...he felt he got their full attention when they were there, however, the wife seems to suggest that the amount of attention her husband received depended on how busy the nurses were. For example, they were less busy at the end of the day and at the end of the week (when most patients were being discharged).

**Questions:** Pts./family members are more likely to ask certain nurses questions over others. Need to explore these differences more (?)

Some differences identified in terms of the patient’s perspective of question asking versus family member.

Patients seems less inclined to ask questions and instead ‘goes along with things’

Wife more inclined to ask ‘important’ questions but also acknowledges ‘going along with things’. The wife afraid that she may not have asked the right questions or remembered to ask all of the questions. (?) Feeling a sense of responsibility as the care giver.

Individuals need to ask questions or they are not going to know...nurses are not going to tell you.

Are there different expectations between nurses, patients and family members around this issue of question asking? Perhaps patients and family members expect nurses will just tell them – provide information but nurses might be thinking that everything is fine and that if people need something or have a question they will ask.

**Expectations:** There seems to be an expressed expectation on the part of the family member that nurses would provide more information about what to expect once discharged from the hospital. Issues such as lack of hospital experience, anxiety and fear re: falling etc... possibly lack of knowledge about possible problems or issues that could come up e.g. pain and who to contact were examples used.

1. **information – nurses have information that patients/family members do not?**

Nurses have more information about patients and their condition than the patients themselves. Patients and family members may lack experience with the hospital environment and they lack knowledge and information about health conditions, diagnostics, treatments, etc… This makes patients and family dependant on nurses for the information that they need to feel secure and to develop a sense of trust in the care they are receiving.

Is it possible that this creates a power imbalance?

Are nurses (unwittingly) protective of this information/knowledge and control the dissemination of information as a form of retaining power and control? Nurses seem willing to give information when asked but how spontaneously do they offer information other than what might be required.

How does this influence nurses’ willingness to collaborate? How does this influence patients and family members willingness/ability to collaborate?

2. **Asking questions – patients/family members get information by asking questions.**

This respondent indicated that question asking was very much part of the process of getting information from nurses and giving/receiving information appears to be essential, if not pivotal to the collaborative process.

According to the patient, collaborating meant security (knowing that she was in good hands). A heightened sense of security and a feeling of reassurance was as outcome of receiving information.

Do patients/family take on a larger role than nurses in the process of collaboration within the hospital setting by: initiating conversations and asking questions?
Do patients/ family feel responsible for this role?
If so, how and why did this role evolve (or was it always there)?

3. **Needing to feel secure – patients/family members want/need information to feel secure.**
Actually, I think that category 2 and 3 are connected ...there seems to be a relationship between that amount or type of information patients have or receive and their sense of security while in hospital.
If asking questions and receiving sufficient responses increases the patient’s/family members level of security what happens to patients/family members who do not ask questions?
Is ‘security’ a concept that is important from the nurses’ perspective?
If it is, how is this assessed? What are the indicators of more or less security?
If it is assessed, are nurses more likely to collaborate with those patients and family members who seem less secure?
Is security the same as trust?

4. **Patients are referred or exposed to (collaborate with ) numerous other HCW’s while hospitalized.**
Patients seem to be exposed to a number of HCW’s in the hospital setting. In many cases this occurs through referrals especially around discharge planning.
This may mean that certain aspects of pt care may not be perceived by the nurse as his/her job? For example, instead of interacting or collaborating with the patient around her spiritual needs would the nurse make a referral to a chaplain instead?
Does this suggest that, if one considers the concept of holistic care (physical, emotional, psychosocial) as well as the transition from hospital to home/community, that there are certain aspects of this process that are nurses domain and other aspects that ‘are not their job’? Are acute care nurses today primarily in the business of providing physical care and to move the patient in and out of the hospital as quickly as possible?

5. **How patients and family members work together/collaborate in the care giving process...**
From the respondents’ perspective, collaborating was important and considered a “personal thing” ...everyone should be upfront and knowing what is going on. This seems to relate once again to information sharing among and between nurses, patient and family members. It was clear that the patient and her husband “shared” everything – talked everything over and they expected nurses to address/inform both of them.
Participation in patient care giving was described as helping with basic needs e.g. dressing and as something that evolved over time. Because the patient was at home ill for several weeks the ‘helping’ began there and carried over into the hospital. The difference in the hospital seemed to be that the patient and family sought permission from the nurses – checking if it was o.k. for the husband to be doing various things. Why would patients/family members feel that they had to seek permission (which also implies they had to take the initiative to ask as opposed to nurses engaging family in a conversation about family participation)? What conditions in the hospital and around nurses create to result in this social process of asking –questions, permission?
Are there control/power forces at work here?
Patients'/family ask; have to wait to ask.

6. Nurses work hard but there are limitations to what they can do.
It seems that patients perceive nurses as working hard in the sense that they are juggling many patient demands at one time and are barely able to just meet the basic needs. Therefore, nurses are limited in what they can do – aren’t god; aren’t miracle workers; can’t be everywhere; can’t be everything to everyone. The patient gained this perspective by watching nurses over a 3 week period and “getting a feel for the ward”. Specifically, how do nurses convey the message that they can only do so much? It is also implied that what nurses can do is limited to providing physical care – managing I.V.’s, giving meds, preparing for Dr visits, etc…- they don’t even have time to write all the things down therefore they need good information retention skills. If this is the case, what does this mean to patients and family members and how does this impact collaboration?
Is there a system of prioritization playing out here that perhaps puts collaborating with patients and families at the bottom of the list in terms of importance?

7. Intelligent selection – nurse are selective in terms of collaborating with families on emotional issues/ families have varying needs of the nurse depending on the degree of family support they have.
Intelligent selection is a very interesting concept that implies a process whereby the nurse assesses who is in greater need of support (emotional or otherwise) and therefore, who she/he will initiate collaboration/interaction/communication with.
It seems there are several factors that influence the nurses “selection”. For example, if the patient has a good support system present then they are less in need of the nurse for emotional support. If, a patient or family member complains a lot this can impact the selection process – on one hand it means that they are very needy of the nurses support but it may also be a deterrent in terms of being ‘selected’ by the nurse.
Another factor may be how ‘aware’ the nurse is of the patient/family members needs. Is this why it is important for patients/family members to take the initiative to ask questions or to get to know nurses and have nurses get to know them?

8. How nurses, patients and family members collaborate (or contribute to the collaborative process)? Getting to KNOW.
Again issues such as: the importance of nurses listening to patient’s concerns as well as the need for patients and family members to ask questions are highlighted here as important aspects of the collaborative process.
Also important is the process of getting to know the nurse, however, in this case the patient seemed to take responsibility for taking the initiative to get to know the nurse. This process was clearly affected by how much a particular nurse worked – if they worked a lot then you were able to “spark up a comradery/ friendship”. It sounded like the nurses who worked on a more regular basis had a much more personal or individualized approach with the patient whereas nurses who did not work as much were more ‘general’ – [person case vs. general case; just a patient in a bed syndrome]
9. Structural/environmental issues that affect collaboration

- Things like food quality, room assignments (private, semi-private etc.), seem to come up consistently so far which makes me think about the 'service industry'. Are people—patients/family members—are looking for quality service from the hospital or are their expectations so low that they are surprised by the quality of service they do receive? If in fact peoples’ expectations are low of the service, does this encompass expectations of nursing care and what influences these expectations? Are people being influenced by the media re: the state of the health care system? How does this relate to collaborative relationships?

- Space is clearly an issue. The respondent notes that sometimes it can get very crowded on the unit or in the room and this makes collaboration difficult although it is not entirely clear to me how the process of collaboration is affected. One would presume that the presence of equipment at the bedside dictates how many people can comfortable fit around the bed and how many people can stay when the nurse is trying to provide direct patient care. But it seems to me that this only restricts family members from being at the bedside for brief periods of time while the nurse gives direct care. Perhaps the issue is that this expectation that family members would leave or move is simply assumed or implicitly implied as opposed to negotiated?

1. What nurses ‘do’. Things nurses do while interacting (collaborating) with patients and family members.

- telling (telling patients what they will do…what care or interventions they will perform)
- giving general guidelines
- listen
- assume
- “check it out”; getting hold of [doctors]
- patient teaching, giving/going through information
- giving pamphlets
- being quick re: interventions, responding to call bells
- normalizing patient responses (physical and emotional) e.g. it’s o.k.
- take out staples
- attend to equipment e.g. IV pump
- do checks—temp., heart rate, pain level
- encourage ambulation; ask about bowels
- joke
- chat; chatty
- did not come in with a long face
- write it down
- ask questions
- give thorough answers; good at explaining things [2-544]
- do extra things e.g. get blanket
- a good nurse, nice nurse is one that explains a lot about what he should be doing and what to expect when he goes home [2-532-534]
- explaining how you are going to feel about different things [538-540]
- encouraging
• preparing [for procedures/interventions] [2-559-567]
• I did ask a few questions, mainly of her because she was more forthcoming... she gave good answers or whatever, you know, she spent the time, she was nice [599-602]
• Some are more personable than others.

See Memo

### Things nurses do

#### Providing care (?)
- General case (?)
  - telling (telling patients what they will do... what care or interventions they will perform)
  - giving general guidelines
  - patient teaching, giving/ going through information
  - giving pamphlets
  - being quick re: interventions, responding to call bells
  - normalizing patient responses (physical and emotional) e.g. it’s o.k.
  - take out staples
  - attend to equipment e.g. IV pump
  - do checks – temp., heart rate, pain level
  - encourage ambulation; ask about bowels

#### Conveying caring (?)
- Person case (?)
  - joke
  - chat; chatty
  - did not come in with a long face
  - do extra things e.g. get blanket
  - give thorough answers
  - good at explaining things
  - listen
  - “check it out” (w/ Dr., supervisor)
  - getting hold of [doctors]
  - being quick re: interventions, responding to call bells
  - write it down
  - ask questions
  - spending the time
  - encouraging
  - prepares patients
  - explains what to expect
  - explains how you will feel
  - being personable

### 2. General case versus person case/ Getting to know vs. just a person in a bed
- Information given by nurses is inaccurate, incomplete, not relevant to pt. situation
- Generalized as opposed to specific to patient’s case
- Information/care conflicts with other nurses, with what the doctor said, with the patient’s information.

### 3. Description of activities/ events associated with hospitalization/ having surgery.
- Pre-admission clinic
- Explaining test; what they were going to do
- Going over drugs
• Having blood tests
• Surgery delayed because of strike
• Waiting for a call
• Being admitted
• Waiting
• Starting IV
• Getting ready
• Seeing the doctor, anesthetist, therapist
• Going to the OR
• Being put out
• General vs. spinal
• Waking up
• Being in recovery
• Checking freezing with ice
• Being in the room – on the pump
• Being kinda awake – in and out
• Nurses checking
• Nothing to eat; lots of water
• Meeting with home care nurse

Satisfied with hospital experience...
• everything ran smooth[25]
• everything went smooth [29]
• everything was looked after all the way along [29]
• never short a nurse-never called a nurse- they were always there[30-32]
• it’s a nice little hospital [886-887]
• meals were good; service was good [891]
• (Pt.)They’re all very good – never felt neglected or anything [93-94]
• (W) I thought they were all very good [99]
• nothing we can say bad about it [110-111]
• all very friendly, very professional [115-116]
• little hospital, nice, nice atmosphere [1095]
• newer hospital, like a little private hospital, it’s so quiet [1102-1103]
• can’t expect any more…even if a nurse was sitting there full time she could not have
done much more than what they did [1185-1187]
• we were very fortunate, the experience was great and everything went well with us and
the medical system has been very good to us.[1154-1156]

Identifying health care workers in the hospital
• I guess it was a volunteer [74]
• I assume a volunteer [87-88]
• they’re all very good, you don’t feel like you were just being neglected [93-94]
• all very friendly, very professional [115-116]
• going back to the nurse...he also explained more about what was happening. Oh, that was
the therapist. [267-274]
Collaborating with other HCW e.g. anesthetist, therapist

- He explained [278]
- Saw the therapist at the pre-op clinic as well – they were very good – showed us the joints that were going to go and how they worked and gave us a list of equipment that would make things easier at home [280-298]
- The therapist was very thorough
- They showed us because we weren’t really sure... the plastic part and how they work; connect [308-311]
- The surgeon told us he didn’t show us [312-313]
- They were very good; very thorough [315-317]

- Wife: originally (pre-admit clinic), he had said that he didn’t want to hear what was going on.[326-328]
- The anesthetist was different to the pre-op [328-329]
- He said to my husband why do you want the general? The spinal is much better for you. [332-333]
- He [husband] explained why and the anesthetist said no problem [332-333]
- If something comes up that you are hearing something that you don’t want or you just want out of it, give me a signal and I’ll give you something and that’s what he did. [333-337]
- Wife thought he was going to be groggy so she didn’t show up until later and was amazed at how good he was; how bright. [337-342]

4. Ways in which patients and family members are excluded or marginalized in care (?)
How collaboration/interaction/participation between nurses, patients and family members may be limited (?)

Hospital rules: description of

- husband not allowed to accompany patient beyond reception area b/c there are too many people
- rules were explained
- family not allowed in recovery area
- having to wait to see patient
- leaving husband at the doorway
- understanding about ‘being in the way’
- not feeling there was much point in staying

Confidentiality:
- do nurses limit information to family because it is a privacy thing... are they not supposed to say anything because of confidentiality?

Not being given information (?) not sure how to categorize??????
Post-op
- not being taken aside
- not sitting you down
- not having conversations
- not asking the questions
One-sided interaction
- nurses telling, doing

Not spending time
- in and out, being quick)

Not their job? Not a priority?

Limited Space
- having to move to make room for nurses
- there’s only so much room [2-912-916]
- ‘stepping side’ [2-937-940]
- needing to move furniture to make room [2-954-957]
- sensed the need to move but didn’t feel offended, rushed [2-9958-960]

5. Absence of/ limited and/or ineffective communication/sharing of information.
- Doctors not informing nurses
- Doctor not leaving complete instructions/orders
- Nurses’ info is general not individualized
- Dr’s give ‘worse case scenario’
- Nurses needing to “get hold of doctors” for information/instructions
- Nurses not informing other nurses
- thinking it’s all straight forward
- expect that patients have already been told –pre-admission clinic or by the doctor.
- leaving it up to the doctors

6. Self-advocating – Looking out for self (?) Interactive processes patients’ engage in with nurses:
- listening
- paying attention
- seek information from other patients and family members
- complying
- saying “No” - telling them [nurses] they are wrong
- telling/giving instructions
- repeating themselves
- correcting information
- needing to be involved
- not speaking English, understanding the situation or asking questions could result in something going wrong.
- Going along with it

Asking questions
- He [pre-admission clinic nurse] was very thorough ...I asked quit a few different questions.
- If you ask questions you will know...[599-600]
- I did ask a few questions of one nurse because she was more forthcoming, gave good answers, spent the time, was nice [600-602]
• if you didn’t ask questions – it [information] didn’t come. [620-622]
• you wouldn’t have known. You would have to ask the questions [624-625]
• if you’re not going to ask questions, they’re not going to tell you and so I guess its up to, to the individual [659-661]
• I was just there and I do ask questions but perhaps some people do not [fades off]. But I think there should be some interaction.[671-672]

7. Feeling vulnerable; lacking a feeling of security/ confidence. Things pts and family members do
• “vulnerable” – worried something could go wrong; worried things would be done that shouldn’t be
• miserable
• scared/anxious
• “emotional mess”
• “I feel like I am just floating around in the wind”
• “something could have gone wrong”
• “I feel like I know more than they [nurses] do!”
• “I want to get better”
• not rational
• not an ordinary case
• dependant on/influenced by info from nurses and doctors
• pt. worried about husband – not being informed, not liking hospitals, his feelings/perceptions re: the patient’s condition/recovery.
• Hating every moment; it was awful; not wanting to do this ever again
• Going along with it b/c supposedly they know what they are doing...unless there is something you don’t feel good about...then you would have to say something; ask questions (P-002).
• Forget to ask questions [2, 3]

8. Time
• Patterns of ‘business’ (e.g. not busy on the weekends vs. busy on Mondays)
• Nursing procedures (e.g. taking temp.) are done quickly
• Nurses are in and out
• Respond quickly to call bells
• Slightly more time on weekends to “chat” but only some nurses do.
• Not expecting it [collaboration] knowing how busy nurses are
• its not that they have time to chit chat [2-477-481]
• nurses seem busier ["on the go"] at certain times e.g. nights [2-569-570]
• staff is down and everybody wants certain little things...[2-574-575]
• strike affected business (number of patients)
• surgery starts Monday and then they move them out for the weekend [2-584-598]
• When you passed the desk/nurses station...not that they should because they were probably being busy doing different things or talking to one another...they might look up but otherwise you just go by and nobody ever said where are you going or what...[2-607-612]
• stayed and did whatever they had to do [2-745-750]
• got the full attention. [2-750]
• Nurses had more time towards the end of the day and then again towards the end of the week b/c there weren’t that many patients
• Some just go in there and do their job and they, and they just say what they have to say [2-766-768]
• being professional first - do their job correctly - but you still should have a little bit of PR [2-769-770]
• there seemed to be quite a few of them at the desk when I went by and yet they didn’t come down that much.[2-775-778]
• there were sufficient nurses [2-793]
• there was always 4-5 nurses at the desk and there could be others in the rooms [2-795-797]
• Sometimes they were busy on the phone or whatever but didn’t appear “wrenched off their feet” [2-802-804]
• Not rushing around [2-808]
• you always hear how nurses are so busy so you don’t really, feel that you should be just talking to them and keeping them in some kind of conversation [2-897-900]
• We all know that nurses are under a lot of stress with the times[2-1138-1139]
• …it was quieter at night so then she had a little bit more time that she could come and chat with you in that respect because during the day you can imagine its busier with people coming and going and people checking out. [2-1069-1072]

9. Getting to know
• Faces are changing all the time
• Expected to come in and get to know [the nurses]
• Expected to say “Hi, how are you” & have a chat
• Don’t know who’s at the desk
• Getting to know (chatting) is important because it makes everyone more comfortable
• Perhaps this is not the nurses’ job
• Different in private facilities
• Nurses are busier in the hospitals/ you always hear how busy they are
• Getting to know is not a priority because nurses are busy and there is not somebody you see on a regular basis.
• Nurses are so much busier –you don’t ever see the same faces; the faces are always different so you don’t ever get to know anybody…you don’t get comfortable.
• Nurses are different – some interact more than others
• There’s not one person whose responsible for checking on a daily basis – this would make the patient happier, less vulnerable

On-call versus regular nurses
• Evening nurses are different – on call. [2-504]
• afternoon nurses seemed to be more on call -only put a couple of shifts in a week [2-513]
• one wasn’t overly well dressed. [2-516]
• doing things differently
only come once a week so they don’t really know who you are...you’re just a, just a patient in a bed. [635-638]
regular daytime nurses would get used to you...[638-645]

10. Factors contributing to variations in Expectations re: the level, form(?)

Type of surgery/ length of stay/ planned vs. emergency/ patients condition
I really didn’t expect it to be honest because I know how busy nurses are and its not that they have time to chit-chat...but it didn’t bother me...perhaps it depends on the type of surgery or the incident. [477-481]
I was very well informed, it wasn’t like it was an emergency operation, that might be a little different situation...it was all planned [261-264]
It’s not like somebody with an accident...take a long time...[380]
he and this other fellow were pretty good. It wasn’t that they were demanding of the nurses’ attention because there wasn’t really anything wrong [386-390]
didn’t call the nurses; waited until they made the rounds [392 395]
[the fellow in the other bed] was the same – he wasn’t in a lot of pain [395-396]
When discussing being addressed by nurses wife states: “but it didn’t at the time bother me...perhaps it depends on the type of surgery or the incident [480-481]
If you weren’t feeling well or if it had been an act that you were really ill and those kind of things rather than just the surgery, which I don’t want to make light of it, but perhaps I would have expected a bit more...rapport with them. [486-495]
It’s not like a real problem or something that you were really having problems with. [504-505]
With the knee people aren’t in for that long – our not really seriously ill [646-649]

Nursing has changed...
used to try to do more for you but there was more time, more nurses
of course we all now what the cutbacks and everything have done [1128-1131]
a management person come on the floor, they used to have like the head nurse It’s really changed the whole atmosphere of nursing [1133-1135]
how they train the nurses today or whatever.[1137]
nurses are under a lot of stress with the times... so we didn’t go in there expecting to be waited on all the time [1138-1142]
you hear things on the radio; people complain [1151-1153]
we were very fortunate, the medical system has been very good to us.[1154-1157]
perhaps its because they are being short staffed and how they are trained these days that is different from the old nurses. [1156-1159]

Memo C1 – July, 2005

(?) Selective Collaboration -
between nurses, patients and/or family members

Acuity
**Preface:** The primary purpose of this study has been stated as: ‘to explain how nurses who are working in acute care hospital settings and patients and family members interact in order to plan and provide care. The term ‘interact’ or ‘interaction’ has been used in a broad sense to refer to interactive processes such as collaboration and decision-making that are assumed to be inherent to nurse, patient and family relationships in acute care hospital settings particularly as they occur around planning and providing care. The underlying assumption in this statement, one that has been driving the data collection phase of this study, is that nurses, patients and family members do indeed, interact (?) – not defined) and collaborate (form partnerships by joining together in their individual roles to plan and possibly implement care), when in fact; this may not be the case, at least not in all situations – according to participant interview data. Conversely, it may be possible that nurses, patients and family members do interact and/or collaborate but to varying degrees and/or in ways that may not fit or are not limited to planning and implanting care as the definition suggests. This having been said, it appears that some form or degree of interaction and collaboration (?) or cooperation (?) is operating which results in the formation of relationships between nurses’, patients and/or family members (or because the data is clear that it doesn’t necessarily involve triadic relationships) in relation to the well-being (but not necessarily planning and implementation of care per say) of the patient and/or family member(s).

---

**Collaboration**

In acute care hospital settings, nurses do not necessarily collaborate with all patients and/or their family – this has been consistently acknowledged by all nurse, patient and family member participants. In fact, the data suggests that there are instances when nurses, patients and especially families do not interact at all – at least not in a ‘therapeutic’ way. In other words, nurse, patient and family collaboration and, to a lesser extent, interaction, as relational modes of operation associated with direct care planning and delivery are neither routine nor expected within acute care hospital settings. What is most surprising about this finding is that participants are generally ‘okay with that’ meaning that there appears to be a level of acceptance or understanding that parameters or conditions around nurse, patient and family interactions exist and are a necessary part of the acute care environment. Indeed, according to many participants, to expect anything more would be unrealistic. This level of acceptance or understanding appears to stem from a keen sense of awareness among participants that due to various contextual and systemic factors operating within the acute care environment (e.g. the ‘busyness’) it is generally not possible or even desirable (on a personal and/or professional level) for nurses to interact and/or particularly to collaborate with all clients (patients and their family). There is however, a certain degree of expectation among all participants that interaction and/or collaboration will occur when the need arises. Hence the commonly used rider “it depends” in response to questions posed by the researcher to the various participants around the conditions giving rise to interactive and/or collaborative experiences.
Before going any further, an attempt to clarify the difference between what is meant by interaction versus collaboration from the various perspectives obtained is required. Interaction seems to consist of various degrees of interpersonal communication that fall under the two subcategories: social interaction and therapeutic (for lack of a better term) interaction. Social interactions constitute ‘acknowledging the other’ and assume the form of a simple greeting. Such greetings however, have various degrees of meaning at least to patients and family members—ultimately, meaning rests on how the greeting is delivered. For example, acknowledging patients and family members by name carries significantly more meaning to patients and family members in terms of making them feel welcome, making them feel like ‘not just another patient in the bed’, giving them the feeling that they could approach that nurse to ask questions. Greeting or other forms of ‘acknowledgement’ by nurses that were delivered with a smile and/or in a friendly, cheerful manner and/or humor also rated higher in terms of meaning for a number of patients and family members.

Social interactions also take the form of what participants commonly refer to as ‘chatting’ and involve discussions that generally have nothing to do with the illness or hospital experience. For example, P-008 referred to discussions she had with the nurse about gardening; P-005 referred to her discussion with nurses about children, pets, etc... As with social greetings, the meaning of social chatting was that it made them feel less like a number and more like: ‘a human being’; ‘an individual’; they were being ‘treated with respect’—an important theme in the majority of interviews completed. It also held therapeutic meaning for patients and their family members in that it ‘helped them fill the days’ or prevented them from not feeling as lonely especially for those patients with fewer family supports. Feeling lonely, disrespected, and/or unhappy because they felt like just a number was commonly linked to slower recovery, poorer overall health outcomes, and created less than favorable conditions for positive relationships with nursing or other hospital staff. Overall, nurse, patient and family member participants believed that social interaction promoted an increased sense of trust and mutual respect between all parties and increased the probability for collaboration.

Despite the belief or perception that social interaction is beneficial, it is interesting to note that a contradiction between perceived benefits and expectation for application or implementation in practice appears to exists. Although patients, family members and several nurse participants talked about the importance of social interaction (NOTE: importance being linked to therapeutic benefits thus supporting the argument that all interaction is potentially therapeutic in one way or another) they were consistently quick to point out that nurses’ generally lack the time to engage in these forms of interaction. For nurse participants, social interaction clearly ranked lower, not so much in terms of meaning but in terms of priority, in patient care. While this seemed to be a source of frustration for some nurse participants others seemed to accept this perceived reality citing patient care (meaning physical care) and safety as being more important. Similarly, patients and family members consistently recognized that lack of nursing time meant that social interaction was not a priority and although many lamented that it would be nice if nurses could dedicate more time to this cause it was important that doing so did not occur to the detriment of ‘patient care’ delivery. Patients and family members typically talked about patient care in relation to meeting basic physical and medical needs such as: getting medications on time,
receiving assistance with feeding, bathing, and toileting, receiving therapy e.g. physio as scheduled, having call bells responded to in a timely manner.

The second sub-category of interaction that occurs between nurses, patients and/or family members is referred to here as ‘therapeutic’ – although I am not convinced that this adjective is accurately or appropriately descriptive in all cases. By therapeutic interaction I refer to interaction that appears more ‘business’ or professionally oriented (perhaps ‘professional interaction’ is a better term). In other words, it describes those interactions that occur as part of basic, routine care delivery e.g. administering medications, delivering meal trays, providing equipment such as towels, providing basic information such as hospital visiting hours, times of doctors’ rounds, details regarding scheduled tests, etc...(examples from participant observation opportunities). In some cases it even extends to the commonly referenced (and observed) act of “checking on” patients. The act of ‘checking on’ typically includes the nurse poking his/her head into the room or around the curtain and inquiring in very general terms if ‘everything is okay”.

In my observation and based on my own experience, the act of ‘checking on’ is usually a purposeful mini-assessment opportunity aimed at gathering objective and/or subjective data is relation to the patient and/or family at that time. The fact that this form of assessment is clearly around obtaining information about patient and/or family well-being begs the question: Is this collaboration? Is it a degree of collaboration on a collaborative continuum? Is it a stage in a collaborative process? Does this form on interaction merely set the stage for the possible development or evolution of a collaborative opportunity or relationship? The answer: It depends! From the perspective of patients and family members, the simple act of ‘checking on” even if it only involves the nurses’ physical presence without any verbal communication provides them with a sense of reassurance that they or their family member is being ‘looked after’. The more often the nurse is physically present to ‘check on’ or even to perform routine nursing care e.g. med. administration every 4 hours, the more likely patients and family members will initiate interaction with nurses by asking questions. The sense of reassurance and the odds of asking questions, however, appear to rise exponentially with how the nurse ‘checks on’ patients and/or family members and performs routine tasks— that is to say that the manner in which the nurses’ verbal and non-verbal is perceived may invite or create a barrier to the initiation of any form of interaction (and consequently collaboration) by patients and/or family members.

Does this mean that interaction is a prerequisite to collaboration? I don’t believe that is the case...at least not in all situations. While there certainly seems to be a relationship between social and therapeutic/professional forms of interaction and collaboration the relationship seems to more categorical (referring to different categories or types of interactive relationships that are not necessarily dependant on one another) as oppose to being hierarchical in nature. Otherwise stated, social interaction, therapeutic interaction and collaboration may all fit under ways in which nurses patients and/or family members interact and communicate they are not necessarily interdependent forms of interaction – one does not depend on the other nor does one form lead to another. What might be argued about the different forms of interaction is that one is of a higher order than the other...but I am not prepared to ‘go there’ yet! For fear of getting ahead of myself I return to the discussion of collaboration as perceived by participants.

Although the notion of collaboration is individually perceived, defined, and experienced depending on any number and combination of variables, based on interview data there does appear to be some common ground among participants in terms of the characteristics that constitute collaborative ‘incidents’ as well as factors and/or conditions that act to either facilitate...
or create barriers to the development and maintenance of collaborative relationships. Returning to the idea that collaboration is not necessarily something that nurses, patients and/or family members engage in, what stands out most strongly about descriptions of collaborative interactions is that they appear to have an episodic quality. What makes these interactions episodic is that they tend to occur on the basis of need. The notion of need however, is a relative term. That is to say, need ‘depends on’ the meaning or importance assigned to it by the nurse, the patient and/or the family member(s) in the context of other competing or influencing variables or forces. Such ‘other’ forces appear to be contextual, systemic and personal in their origin and include for example: acuity, time, and rapport. Of course, assigning meaning and priority to a need is contingent on the need being identified and/or communicated in the first place.

While specific competing and influencing forces will be discussed separately, suffice to say that the significance placed on these and other variables by the nurse, the patient and/or by the family member(s) affect the meaning and significance placed on the need itself and vice versa. This in turn contributes to the determination of both need and priority of need in relation to the establishment and possibly the maintenance of collaborative episodes. Moreover, since the nurse, patient and/or family member(s) may potentially hold competing or incompatible perceptions with one another regarding need and other variables, it seems, although not in all cases, that the form and degree that collaborative episodes assume are somewhat dependant on the degree of established or negotiated shared meaning or significance (this idea needs more development) placed on the need. Furthermore, situations in which nurses, patients and/or family members fail to negotiate meaning may result in a ‘withdrawing’ from establishing or maintaining the collaborative relationship. This means that nurses, patients and/or family members may also be considered a form of influence that actively affects the development and/or conditions of collaboration. In this context collaboration appears to be not only episodic but also ‘selective’ in nature. It is episodic in the sense that it is dependant on need and it is selective in the sense that the need is dependant on the weighting of multiple variables to determine the priority status relative to engaging in a collaborative relationship.

Issues associated with the identification and/or communication of need tend to be dependant on what was frequently described by participants as ‘personality’ characteristics but is also associated with beliefs about power, and responsibility. For example, some patients and family members described themselves and/or in some cases, their perception of each other as being not very ‘sociable’, ‘personable’ or ‘friendly’. If they were referring to themselves this usually meant that they did not feel they had the social or ‘other’ skills necessary to interact with others (e.g. they were shy or felt they were not able to express themselves clearly). If they were referring to the nurse it generally meant that the nurse was perceived to be ‘unfriendly’ and therefore, unapproachable. If they were referring to other patients and/or patient’s family it included the possible perception that they were demanding and that their expectations of nurses were unrealistic. So called demanding individuals were referred to as the ‘squeaky wheel’ and will be discussed separately. Several nurses, patients and family members believed that patients and family members have a responsibility to ‘let the nurses know what their needs are’. Other participants (primarily patients and family members) expressed the belief that the nurses were ultimately ‘in charge’ and abdicated responsibility for need identification and prioritization to them. This appeared to be in opposition to the fact that nurses generally acknowledged that they did depend to a certain extent on patients and family members to identify their need – for attention and potentially collaboration – especially if they did not automatically fall into a nurse
imposed category of those requiring priority care. As a side note, the fact that nurses do indeed, identify certain patients as requiring more attention than others does suggest that there is an inequitable power distribution factor at work (this will be discussed in more detail as it relates to the issue of acuity). If patients and/or family members were not among those receiving priority care and did not identify their need for care/attention, these patients and/or family members may be ‘missed’ by nurses – a phenomenon identified as ‘falling through the cracks’. For example, N-008 states: “...if there is a stage where a patient is really ill then you are definitely, you know, the sickest patient, you are collaborating more with them and with the family and keeping the family up to date...And then there’s patients who are doing, they are stable, I, you kinda miss them. They're the ones that don’t get my attention very much because they are stable and there’s the ones that are getting ready to go home – they get a bit more attention too because you have to make sure you meet all their needs when they leave the hospital” (p. 5).

**Acuity**

One of the primary factors identified by nurses, patients and family member participants pertaining to need identification was the notion of patient acuity and the relationship between acuity and allocation of nursing time. Generally speaking, nurses agree that sicker patients and/or their family require more interaction and more collaboration to meet the physical and/or psycho/social/emotional needs associated with acute illness than do those patients who are considered ‘less acute’, ‘more independent’ or generally ‘stable’. Patient and family member participants concur that the sicker the patient the more they depend on the nurses for care, information and support. One nurse participant (N-014) describes the allocation of nursing time as follows: “...it’s actually to do with the acuity of the patient. It sorta involves my time so the more acute they are the more time I spend with them and if they are not progressing um, as well, then I end up spending more time with them – either with the patient, it doesn’t necessarily involve the family but I could be spending more time with that patient than with my other patients that could be progressing well or are less acute...” (p.6)

In describing her perception of the factors that contribute to collaboration F-007 states: “Well I would hope that it would be need. Um, mind you some of these people’s needs are different than others but I mean I would think it would certainly be a matter of uh, the degree of illness, I would hope, uh, the degree of care that is required for that individual as opposed to routine or more routine care” (p. 6).

While the degree of patient acuity seems to correspond with the amount of time nurses allocate to patients and/or families, does it necessarily correspond to the development and/or maintenance of collaborative relationships? Answer: ‘it depends’. Some of the key dependant factors include, but are not limited to:

- The nature of the patient’s illness or condition (medical diagnosis)
- The degree of coping and/or ability to managing the illness or condition demonstrated by patients and/or family members (based on nursing assessment or as expressed by patients and/or family members).
- Routine medical and/or nursing care associated with particular illnesses or conditions
- Any or all of the above as they compare to other patient’s acuity and other factors taken into account in allocation of nursing time (e.g. routine nursing tasks such as paper work, squeaky wheels).
The nature of the patient’s illness or condition relates to the medical diagnosis itself as well as the degree of illness which in turn, dictates the nature and level of expected and/or perceived care that is required. Generally speaking, the more serious the diagnosis or the sicker the patient is from the medical/nursing perspective, the more nursing time is allocated to that patient and/or their family. For example, nurse participants agree that the closer the patient is to death (regardless of diagnosis) the more time they are likely to spend with that patient and/or their family. Based on examples provided by nurse participants, it is assumed that both patients whose condition is considered palliative (dying) and their family are in greater need of support and information from nurses. Consequently, the nurse will initiate a relationship with patients (if they are conscious or lucid) and/or the family in an effort to identify and satisfy these needs. (As a side note, it is interesting to observe that although this study relates to acute care hospital settings and data was collected in such settings, patients considered ‘palliative’ who were being cared for on acute care units represented a large percentage of the patient population on many of the units. This fact had a huge impact on allocation of nursing time and many nurse, patient and family member perceptions of collaboration were expressed in this context.).

If the level of acuity is such that the patient’s life is immediately threatened (death is possible) by an emergency situation (e.g. a cardiac arrest) then medical and physical care of the patient becomes the priority. Despite the recognition that family members likely have many questions and concerns regarding the well being of their ill family member collaboration is not likely to be a priority. From the perspective of the nurse, meeting the patient’s physical needs (care and safety) in these situations come first and collaboration with patient and/or family around care is of lesser importance at least at that time.

Other examples of acuity measured on the basis of ‘threat to life’ include those patients who are considered ‘fresh post-ops’, new admissions especially if they come from the emergency department, and patients who have been newly diagnosed with a life altering illness or injury (e.g. cancer, amputation). Such patients are considered a priority in terms of allocation of nursing time because they are viewed as being less stable physically (have a higher probability for life threatening complications) and emotionally. Consequently, these patients require more frequent physical assessment, care and support. These patients are also considered to be less independent in terms of self care and rely on nurses and possibly family members for assistance. In terms of collaboration, nurses are more likely to consider these patients and their family higher priority because they are generally viewed as needing large amounts of information, teaching and reassurance. Patients and family members concur that they often feel frightened and overwhelmed by such things as diagnosis, treatment, prognosis, medical terminology, hospital routines and fear of the unknown. For example, one nurse participant (N-002) offers an example of the importance of collaborating with a newly diagnosed cancer patient and their family. She states:

“I think for a lot of families it is very important because they are overwhelmed by the information, they are overwhelmed by the diagnosis. They don’t know the medical terminology or they hear a little bit and they don’t understand it fully. So sometimes they can’t really make a decision because they are so confused by everything” (p.3).

Nurses also recognize that family members also have numerous questions about the ill family member’s appearance or general condition, level of pain, etc...and often require support, reassurance and instruction regarding patient care do’s and don’ts. In such cases nurses are more likely to initiate collaboration with patients (if conscious and lucid) and/or family members
based primarily around teaching and information giving. Including family members in teaching interventions is important from the nurses’ perspective because as one nurse put it: “4 ears are better than 2’. In other words, the more family members that hear the information in addition to the patient the more likely the information is to be retained and complied with. Thus, nurses are more likely to collaborate with patients and/or their family who are perceived to be high risk for poor compliance (e.g. those patients who have altered states of consciousness or awareness secondary to condition, medications, age, lifestyle, etc...).

The priority for collaboration based on acuity declines steadily however, with number of days post-op or post-admission because it is assumed and/or expected that these patients are increasingly more stable, more independent and generally have less need for the nurses’ assistance and attention. Patients and family members tend to concur. As one patient described “in the beginning your supportive circle is primarily your nursing staff and then it broadens as the patient gets a little stronger and then you get to the point where I am now and that supportive circle is going to be stretching out even more…” (p.18).

Patient teaching to promote compliance and decrease the likelihood of readmission is also a priority reason why nurses tend to allocate more time to and are thus more likely to collaborate with patients being discharged from hospital and their family. According to many nurse participants discharge planning and implementation of discharge teaching (especially when it involves placement in another facility or in the home with home care assistance or transition issues) is very time consuming and requires a considerable amount of coordination between nurses or patient care coordinators and patients and/or families.

Side Note: The question posed at this time is: Is patient/family teaching considered collaboration? If patient family teaching is considered to be an act of the nurse, patient and/or family ‘joining together in their roles (the roles being the nurse who ‘has knowledge and information’ and the patient/family who ‘are in need of information’ for the purpose of planning and implementing care then technically it could be considered a collaborative episode. What is clear from the data is that examples of collaboration provided by participants generally revolve around the need for and exchange of information.

The degree of coping and/or ability to manage the illness or condition as demonstrated by patients and/or family members (based on nursing assessment or as expressed by patients and/or family members) is another consideration in determining need and need priority in relation to collaboration. Factors related to coping and ability to manage illness have already been touched on from the perspective of issues related to patients who are fresh post-op, newly admitted, newly diagnosed or with those require discharge planning. It can however, be based on other factors that come up from time to time as identified by the nurse or as expressed by the patient and/or family. For example, several nurse participants described situations in which they, at the request of the patient and/or family member(s) are called upon to collaborate with the family in the role of advocate and/or liaison to help resolve or improve understanding, communication and/or decision making related to for example, treatment options. Another example is when nurses identify that family members’ own needs are not being met and that their health is in jeopardy (e.g. spending too much time at the hospital and not getting enough rest). In summary, it seems that becoming aware of factors that pose a danger or difficulty to clients - be they patients or family members – either through observation or direct communication, act to increase the priority for collaboration from the nurses’ perspective.
While it may be argued that a positive correlation exists between acuity and allocation of nursing time in acute care settings, it would be incorrect to assume that increased nursing time spent on the basis of acuity alone necessarily constitutes the need for collaboration. This is supported by negative cases in which allocation of nursing time is influenced by patients whose condition may be medically stable but they are considered acute from the perspective that they require a considerable amount of basic physical care and/or supervision to ensure their safety and well-being. Often this type of patient is unable to participate in a collaborative relationship due to cognitive deficiencies such as confusion or dementia secondary to age and/or other co-existing conditions. Even if the patient is not confused but is requiring large amounts of nursing care such care can be and is delivered without collaboration. To complicate matters further however, such patients are most commonly the frail elderly who may have no family or support persons who are available or willing to assist them while in hospital. This means nurses must provide all care and even if there was a need for collaboration identified there are no family members or significant care persons available to collaborate with.

Does the presence of family members at the bedside increase the likelihood of collaboration with nurses? Not necessarily. As many nurse, patient and family member participants’ state, patients tend to be ‘happier’ and ‘more content’ when family members are present and consequently they have less need for the nurse. Nurses are therefore able to allocate time to patients considered to be in greater need of their time and attention. On the other hand, according to many nurse participants, the fact that family members are present and ‘available’ increases the odds of collaboration because: should an issue arise (e.g. patient won’t eat hospital food) it is convenient for the nurse to ‘enlist’ the family’s assistance (e.g. feeding the patient or bringing in favorite foods). Indeed, many family member participants describe how they have been ‘included in care’ or been ‘supported in their efforts to participate in care’ — meaning giving basic care assistance to the ill family member (feeding, bathing, toileting) which to them constitutes collaboration or ‘working with or helping the nurses’ to ensure the patient receives the care they need (or family members believe they should have).

Nurse participants also report that collaboration is more likely to occur with patients and/or family members who have had e.g. previous bad experiences in hospital, have difficult family relationships or dynamics, co-existing medical conditions that complicate or compromise health/recovery, or any kind of issue that that nurses’ become aware of either by means of chart data or interaction (casual/social or purposeful) with other health care workers, the patient or the family members that suggests a possible need for further interaction and collaboration. Often ‘need’ becomes apparent simply by the patient and/or family member expressing a need — usually in the form of a question or spontaneously sharing information with the nurse. In this case however, the question and or information is interpreted by the nurse as either warranting further investigation and action or not (decision making based on meaning/significance). Meaning associated with such symbols (e.g. questions) is often influenced by other factors such as acuity and time. The less acute the patient and the less time the nurse has available, the less meaning/ significance the nurse is likely to place on the question resulting in a reduced likelihood for collaboration.

In summary, while the notion of acuity is variably defined depending on: a) the context and b) whose is defining it, generally speaking, the descriptions that emerges from participant accounts tend to conform to a hierarchy or continuum of need that reflects the degree to which patients’ and/or family members’ well being is threatened. ‘Well being’ may encompass physical/psycho/social/emotional safety, recovery as well as threatened or imminent loss of life!
A common perception therefore, is that the more one’s life is threatened the more acute they become (on a scale of more or less acute); the more acute they become the greater their need for nursing care. Although logically it would seem that the amount of required nursing care would be positively correlated with the amount of interaction and/or collaboration between the nurse, patient and/or family this is not necessarily the case. In other words, the provision of physical care alone does not constitute collaboration whereas ‘closeness to death’ does. Everything else is subject to a process of priority identification in the context of multiple other factors – a process that appears to be nurse driven. Even when patients make an effort to equalize power by being a squeaky wheel this has the potential of backfiring by causing the nurse to eventually ‘step back’!

**Barriers to Interaction and Collaboration:**

**Availability/convenience:** Collaboration between nurses and family members is dependant on how available the nurse and/or family is. Many nurse participants have indicated that some patients (especially the elderly) have no or very limited amounts of family support. Consequently, unless the patient is well enough to engage in collaboration there is no one with whom the nurse can collaborate with if they wanted to.

In some instances it seems that selective collaboration is based on a convenience factor. In other words, nurses may be more inclined to collaborate with family if they happen to be around particularly at the time when the nurse requires information (N-010).

**Compliance:** Another barrier to collaboration by nurses is lack of patient and/or family compliance. Nurse participants repeatedly indicated that they are less likely to want to ‘do anything extra’ beyond providing basic care for patients who were unwilling to help themselves. They feel less inclined to collaborate when family members are perceived as being obstructive to care but they recognize that this is not the fault of the patient. Nurse, will therefore, make an effort to advocate on the patient’s behalf with the family…to a point. The point at which nurses stop trying and ‘step back’ varies and in most cases nurses could not identify the basis on which they would step back. It does seem to be time sensitive though – if after a ‘certain amount of time’ there seems to no change in behavior or if bringing about said change is taking too much time away from other patients then they are more likely to step back.

**Confidentiality:** Who the nurse collaborates with also varies on the basis of confidentiality. Nurse participants have been very clear that they are often limited in their ability to provide information to patients and/or family members due to hospital/professional confidentiality issues e.g. discussing diagnosis, treatment, care with family members without permission of the patient. While patients and family members seem to understand the importance of confidentiality (and in some cases value it) many see it as a barrier to the building of collaborative relationships.

**Scope of Practice:** Some nurse participants felt that it is not within their scope of practice or their ability to interact with family. Reasons for this include: a) they do not have the information or knowledge to answer questions b) it is more appropriate that questions related to diagnosis, treatment, etc… be answered by the physician, c) issues that involve family e.g. discharge planning or placement are better left to the social worker or the patient care coordinator. Nurse, patient and family member participants agree that often there is a lack of communication between health care professionals e.g. nurse – nurse and doctor-nurse. This is especially problematic when information regarding specific individualized care is not communicated clearly and patients/family are constantly put in a position of ‘educating’ staff about their condition and/or special needs. This contributes to the perception that nurses are not
knowledgeable which in turn undermines the building of trust— a necessary pre-requisite to collaboration.

Respect: Nurse participants’ acknowledge that they are less likely to engage in interaction or collaboration with patients/family members who are disrespectful towards them e.g. treat them like handmaidens, have unrealistic expectations and demands, and ignore their authority. Some nurse participants have also noted that they are less likely to interact with family members who they perceive to be disrespectful or unsupportive to the patient. Examples of this include: family members who come at all hours of the day and night and disrupt the patients rest, patients appear anxious when certain family members are present – dysfunctional family situations that are being played out in the hospital setting, issues related to prejudice. One participant described an experience in which the family members did not believe she was competent on the basis of her race. This incident invoked ‘stepping back’ described by the nurse as ‘proving necessary care for the patient but spending less time with the patient when the family is present’ (N-010 p12). From the patient’s perspective, they are more likely to interact with nurses who do not make them feel like “just another patient in a bed” and/or with whom they perceive to be: cheerful, happy, helpful, friendly, caring, knowledgeable, and competent.

Language barriers: Nurses are more likely to collaborate with patients and family members who speak English. While nurses do attempt to interact with non-English speaking clients, these efforts will likely be time/effort limited. In other words, nurses will make an initial attempt at communicating through verbal and non-verbal means for a non-specified amount of time. If their efforts exceed this time they will likely move on to the next patient/task. Some patient participants have also identified that when English is not the first language of the nurse communication can be more difficult (although not impossible) and the patient may be less inclined to initiate interaction.

“Personality”: A number of participants claimed that some patients, family members and nurses are not easy to communicate with because they are not ‘as forthcoming with information’ as compared to others. One patient described himself as ‘not being very talkative’ and he believed that this was a barrier to interaction and collaboration between himself and nurses. Another patient believed that men are generally not as communicative as women therefore nurses should put more effort into getting to know people and ‘drawing them out’ if they are less talkative. Many participants indicate that willingness to participate is an important pre-requisite to interaction and collaboration. Some nurses, patients and family members ‘seem’ less willing as evidenced by the lack of information they provide e.g. short answers. This is definitely viewed as a barrier to further interaction.

Time: How much time the nurse has is probably the second biggest predictor of who he/she will most likely collaborate with. Nurse participants have consistently indicated that in the acute care setting patient care comes first. If time is limited then nurses will likely limit their interaction to the patient and this generally occurs around episodes of care giving. Having said this however, time is also related to patient acuity. As discussed previously, the sicker the patient the more likely the nurse will initiate collaboration with the patient and/or family. This is because nurses generally believe that patients and family members have a heightened need for information and support during acute illness episodes especially when there is a threat to life as compared to patients who are considered more stable and independent. An exception to this is when a patient is experiencing a critical incident such as a cardiac arrest. In such cases the focus of care
becomes the patient and nurses admit that there is little time to interact with family until the crisis is resolved. Indeed, often family members are asked to ‘step out’ during these times.

The ‘squeaky wheel’: Several participants – nurses, patients and family members alike – relate to the notion of the ‘squeaky wheel’ in the acute care settings. The squeaky wheel is the patient and/or family member who frequently seeks or demands attention from the nurses. Patients often do this by ringing their call bell – often for reasons deemed by others to be unimportant or lacking in urgency. Family members are often classified as squeaky wheels when they ask too many questions or make frequent and unreasonable demands of the nurses. Often these family members are viewed as aggressive and non-trusting of health care workers as evidenced by such behavior as “writing things down” (N-010), “questioning the nurses about care”. Some nurse participants admit that they feel “cautious” (N-010) and vulnerable when interacting with such family members and consequently they either interact with these family members more in an effort to please them or simply try to avoid interaction as much as possible. As one nurse participant described, on some occasions nurses are encouraged by their manager to give more attention to demanding families. This can make nurses feel “uncomfortable” because it is perceived to be unfair to the less demanding clients (N-010 p.11). This feeling may invoke a process of ‘stepping back’ whereby nurses begin to put limits around the frequency and type of interaction and or collaboration they have with demanding patients and/or family. Stepping back is commonly described as “I do what I need to do for the patient and for the family...I try to do what I need to do and get out and then I go to the next [patient]” (N-010 p11) and “I’ll address their issues in the same way that I address other people but it is just a different atmosphere” – I can’t talk as well because I am more nervous, cautious about what I say (N-010 p.12). Part of stepping back then may be that the nurse ‘holds back’ details that they may otherwise share. It may be a matter of responding to questions and care that meet the required standard but no more.

Stepping Back:
The phenomenon of ‘stepping back’ can be one way that nurses use to manage or distribute their time among patients/family. Stepping back can also be the way in which nurses (and patients and family members) manage difficult or non-harmonious encounters with one another. For example, there seems to be a limit imposed by nurses related to the acceptable amount of time they can spend interacting with any one patient or family before they begin worrying about all the other work they have to do or creating the perception of favoritism – that is spending more time with one than the other. When the nurse becomes ‘aware’ that the time limit is being reached they begin the process of limit setting or stepping back. The act of stepping back on the basis of limiting time seems to be invoked by feelings of: moral distress (I ought to be spending time with all patients regardless of...), professional obligation (I have to spend time with all patients in order to be ‘fair’ and make sure they are safe), simply being human (Just because I am a nurse doesn’t mean I have to put up with certain behavior from individuals – there is a certain amount of respect that I deserve as a professional), etc...

There are also times during the day when taking up nursing time e.g. asking a question(s), is more acceptable than other times. For example, some nurse participants indicate that they encourage patients to ask their questions when they are at the bedside for other reasons e.g. ‘checking, giving out meds, etc... It seems less acceptable for the patient or family member to call the nurse in specifically for this purpose unless it relates directly to the patient and patient care. In other words, it is okay, even expected that the nurse should be called if the questions
relate to malfunctioning equipment, a change in patient condition, etc... If there are too many
incidents of what the nurse perceives to be false alarms (‘crying wolf’), he/she may invoke the
process of ‘stepping back’. Stepping back in this case could mean anything from expressly
setting limits about appropriate reasons for calling the nurse to simply not responding to the calls
as efficiently as he/she may have been done previously.
It also seems that questions are less welcome during times when the nurses are responding to
critical or serious patient health concerns. Even though nurses recognize that family members are
anxious and want to know what is going on the patient’s needs take priority over family member
needs. Moreover, family members who are anxious and asking many questions may be viewed as
a hindrance to patient care because they are distracting the nurse and/or making the patient more
anxious and restless.
Because many nurses believe that “one questions leads to two,” they may consciously or
unconsciously discourage the ‘asking of questions process’ through body language. This is done
by, for example, avoiding the patient or family and/or looking busy or unapproachable. As N-
012 states: “Nurses scurry about and that means we don’t want to talk to you (p.11, 330). The
belief is that when nurses ‘look busy’ patients and family are less likely to disturb them.

More on Questions:
Aside from the signals nurses project that either invite or discourage the asking of questions,
another disadvantage of this behavioral pattern is that some patients and families posses certain
personality characteristics or personal beliefs that limits their ability or willingness to ask
questions either at all or in a timely manner. For example, some patients and family members
express the belief that nurses are so busy that one shouldn’t bother them. Other’s feel that there
are too many other patients that are sicker or needier than they are or their family member is and
that they shouldn’t take the nurses away from providing care for these other people. In terms of
personality traits, some patient participants acknowledge that they or some people are simply not
very communicative. They are not ‘talkers” as one patient put it. The other end of the spectrum,
of course, is the squeaky wheel personalities that are not afraid to take initiative or be assertive.
The concern here is that if nurses depend on patients and/or family members to signal the need
for interaction by asking questions but some patients and/or family members do not or are unable
to take the initiative to ask questions, what is the impact of this on nurse, patient family
interaction? Are these the patients and family members who “fall through the cracks”? If so, what
is the significance of this?
Despite the fact that question asking as a means of need identification has many disadvantages,
all participants agree that this method of communication is one of the most common ways that
interaction between nurses, patients and family members occurs. Indeed, the asking of questions
appears to be the fundamental patterned behavioral process that has evolved as a mutually
agreeable method of managing the problem of need identification and communication in the
context of nurse busyness.
From the perspective of patients and family members, they understand and seem to accept the
fact that, generally, the best way to get information regarding their or their sick family member’s
status is to ask the nurse. The nurse is the best, and in some cases only choice because doctors
are rarely seen whereas nurses work long hours and are more readily available. Although nurses
are more visible, patients and family members understand that nurses may not spontaneously
offer information because they are too busy...Patient’s and family members alike base their
perception of nurse busyness on such observations as: a) they don’t walk they run b) they are in
and out c) the bells are ringing non-stop d) patients are coming (admissions) and going (discharge) and they are having to deal with this e) they have many people to care for f) some patients are sicker and need the nurse more than others – the sicker patients take up their time; they seem to have an awful lot of paperwork. They also report that it is understandable that nurses may not know specifically what concerns patients and family members have and so it is the responsibility of the patient or family member to ask. Similarly, most nurse participants report that if patients and family members have a problem or concern, they will ring or ask questions. Patients and family members asking questions is positively regarded because it helps nurses narrow down what their concerns are and what information to give (N-010, p13). Also, some clients don’t want to talk or aren’t ready to talk...asking questions may help nurses efforts to assess patient/family ‘readiness’ or willingness to talk. It seems that generally, nurses have come to depend on this question asking process as a method for patients and family members to signal the need for interaction and/or collaboration. If patients and family members do not ring or ask questions the nurse is likely to assume that everything is fine and will then allocate more time to initiating interaction and/or collaboration with those who are sicker and/or indicating/signaling (e.g. by asking questions) a need. Thus, question asking is a factor used by nurses to distribute and prioritize their time between patients. The process or behavioral pattern of question asking has many benefits. First of all, it provides an efficient way for nurses to identify and respond to priority patient/family needs and concerns. Secondly, when nurses respond to questions family members and patients report feeling more reassured about the care that their sick family member is receiving which in turn promotes feelings of trust. As some patients (P-001, P-005, P-008) put it, interacting with nurses helps family members understand the diagnosis or patient’s condition better and makes them feel part of what is going on. As one patient described: ‘it is like not being included at a party – when nurses provide information to family members they feel included in what is going on’ (P- ). Being included/informed results in a heightened sense of reassurance in the family member and promotes increased empathy for the sick family member which is often an important factor in the patient–family relationship especially with the primary support person or caregiver. From the nurses’ perspective, the more reassured patients and family members feel the more cooperative they tend to be. Also, when nurses respond to questions the pattern of question asking and answering is reinforced and in some cases, patients and family members then feel more comfortable asking more questions.

Of course nurses, patients and family member participants acknowledge that nurses don’t always have the answers to give to patients and family members. Also, nurses sometimes feel that giving certain information falls outside their scope of practice and/or confidentiality guidelines. In these situations, being honest with clients is important and patients and family members appreciate this as much as when they are able to provide answers. (N-010, p8).

**Rapport/Getting to Know:**

This sub-concept is currently undergoing further development :)

- **Social ‘Chatting’** (also discussed previously under collaboration) – It is interesting to note that nurse, patient and family participants alike acknowledge the importance of social chatting in the acute care settings. Patients and family members report that when nurses are cheerful, friendly, personable, and smile they are more likely to initiate interaction with them. Many patient and family member participants also appreciate short
conversations with nurses that have nothing to do with hospitalization e.g. personal disclosure about family, discussions about gardening or other interests. Patients and family member as well as nurses identified these interactions as important to the process of rapport building. Moreover, when a rapport has been established nurses, patient and family members are more likely to engage in more spontaneous and frequent interaction. Establishing a rapport is important to patients because it makes them feel more like a human being and not just another patient in a bed and feel more ‘reassured’ in the care they are receiving. It is important to family members because they: a) also feel reassured that their sick family member is getting competent care, b) feel welcome in the hospital and valued in their role as support person and c) they report that their sick family member seems happier which is viewed as important to the recovery process. As mentioned previously, as the rapport changes from professional to social the patient and family feel more reassured that the patient is improving.

Nurses’ believe that rapport building is important to the healing/recovery process because patients and family members (especially if they are primary care givers) are more likely to cooperate or comply with treatment/care recommendations. Nurses are more likely to interact and collaborate with patients and family members who are cooperative and compliant.

- **Building Rapport**: Nurses are more likely to collaborate with patients and/or family members with whom they have established a rapport. Building a rapport occurs over time – either extended stays or repeat admissions. Rapport also changes over time. Initially the rapport is of a more professional nature – built on interaction/collaboration related to the health condition and care/treatment. Over time and as (if) the patient’s condition improves the rapport becomes more social in nature. This process of rapport development seems to be mutually acceptable, indeed welcomed, by all parties. From the perspective of patients and family members the change in rapport with nurses from professional to social is interpreted as meaning that the patient is getting better.