Advance Care Planning between Registered Nurses and their Acute Care Patients

by

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B.ScN., Laurentian University, 2000
M.Sc., McMaster University, 2003

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Abstract

Canadians are living longer with multiple complex illnesses. In turn, older adults are often in need of complex medical attention in crisis situations in acute care hospital settings. Although acute care settings are equipped with a growing variety of life saving technologies, hospitals are still the setting in which most people die. Yet, almost half of the Canadians who have been admitted to acute care centres with chronic life-limiting illnesses have not had advance care planning (ACP) conversations with their substitute decision-maker (SDM) about the personal values that bring quality to their lives. In fact, only 8% of the general Canadian population are ACP ready. Consequently, many SDMs are unprepared to make end of life (EOL) treatment decisions for their loved ones.

One way to promote patient-centred care and ease the burden of in-the-moment EOL treatment decisions made by SDMs, is for nurses to engage their patients in ACP. However, very few registered nurses regularly engage their patients in ACP. The purpose of this research is to better understand the organizational factors influencing nurses' decisions related to ACP in their hospital-based work. This ethnographic study was conducted on three acute care wards in two hospital sites located in Northern Ontario. Data collection methods included observational fieldwork, semi-structured interviews with administrators and registered nurses (n=23), and the collection of documents pertinent to the study purpose (i.e., accreditation reports, practice guidelines, etc.). Findings reveal that the work of nurses in hospital settings is embedded within a context that prioritizes patient flow, and efficiency. Consequently, hospitals often function at overcapacity, and nurses have extremely heavy workloads caring for complex patients with diagnoses that do not match the medical specialty of the units. Although participants state that they value ACP, they maintain that nurses have very little capacity to engage patients in these conversations in their practice. Findings support that expectations for hospital nurses to fully engage in ACP with their patients may be unrealistic given the context within which they work. Alternative models for considering ACP in acute care could be explored to ensure that patients with life-limiting conditions receive care that is best matched to their needs, values, and wishes.

Keywords: advance care planning; ethnography; acute care; hospital

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Chapter One: Introduction

There is an epidemiological trend in Canada towards increased life expectancies, and it is estimated that by 2030, 23% of the Canadian population will be 65 years of age or older (Government of Canada, 2014). Experts associate this trend with advancements in medical research and technology, widespread lifestyle changes such as smoking cessation, healthier diets, increased physical activity, and environmental changes (Statistics Canada, 2019a). As Canadians age, there are more older adults living with multiple comorbidities, requiring admission to acute care settings for exacerbations of chronic illnesses or for end-of-life (EOL) care (CIHI, 2021; Miedema, 2013). Unfortunately, some older patients experience challenges at the EOL in acute care settings (Heckel et al., 2020). For example, there have been instances where patients who have not had EOL discussions with their substitute decision maker (SDM) received treatment in acute care hospitals that was more aggressive, less aggressive, or inconsistent with their values (Drought & Koenig, 2002; Heyland et al., 2013; Teno et al., 2000). Overtreatment at the EOL is not a new research finding. In fact, Connors et al. (1995) found that almost 50% of the adults admitted to hospital with a life limiting illness and a 6-month mortality rate were still receiving aggressive treatments that were ultimately futile. More than 15 years later, Walker et al. (2011) found that the majority of health care costs for patients at the EOL were spent on aggressive acute care treatments. On the other hand, there are also hospitalized patients at the EOL who are undertreated, with unrelieved physical symptoms such as pain (Clark et al., 2015) and unaddressed psychological needs (Gagnon & Duggleby, 2014).

The challenges experienced by acute care patients at the EOL have resulted in the development of initiatives aimed at improving the quality of their care. In some acute care settings, palliative care teams are charged with enhancing the care of dying patients (Higginson et al., 2002), and in other settings, frameworks and pathways are used to measure and standardize care (Gold Standards Framework, 2010). Still in other locations, educational initiatives (Shorr et al., 2000) or communication programs (DeCourcey et al., 2021) have been implemented to promote a good death. Extensive attention has also been given to a participatory upstream communication process called advance care planning (ACP), a process aimed at improving the dying experience for acute care patients and their families.

Research suggests that ACP can lead to a better alignment of EOL medical treatments with patient values, thereby increasing the quality of EOL care for patients, reducing the decision-making burden for bereaved family members, maintaining patient control, reducing hospital admissions, improving EOL communications, and reducing moral distress for staff (Brinkman-Stoppelenburg et al., 2014; Detering et al., 2010; Houben et al., 2014; Jimenez et al., 2018; McMahan et al., 2020; Stewart et al., 2011). ACP EOL discussions also increase the likelihood that health care will be consistent with the patient's values (Brinkman-Stoppelenburg et al., 2014; Houben et al., 2014), assist SDMs and clinicians in making treatment decisions for patients who do not have capacity (Reitjens et al., 2017), and lower health care costs (Starr et al., 2019).

While it is clear that it can have positive effects on patients and family members, ACP has not been taken up to the degree that it could be. In fact, research from a Canadian survey suggests that less than 50% of the general population have engaged in ACP (Canadian Hospice

Palliative Care Association, 2013). One of the reasons for low uptake of ACP by Canadians may be the relative lack of clarity on who should be responsible for ACP conversations. Some scholars argue that nurses, as the patient's primary caregiver, are in a unique position to engage patients with life-limiting illnesses in conversations outside of prognostication or treatment decision-making to clarify patient values and fears, which can be useful information for the SDM in their treatment decisions (Cadge et al., 2021; Izumi, 2017). However, ACP is still not a widespread role taken by the majority of acute care nurses. Some studies show that in Canada, acute care nurses report engaging 20-40% of their patient population in ACP (Boyd et al., 2011; Duke & Thompson, 2007; Rietze et al., 2018). This is similar to the findings of Arnett et al. (2016), who found that 31% of American registered nurses working in diverse health care settings engaged the patient/SDM in ACP. From the patient's perspective, only 8% of Canadian patients reported having the conversation with their registered nurse (Heyland et al., 2013), and 5.8% of hospital-based older patients reported ACP discussions while hospitalized in Australia (Detering et al., 2021). The discrepancy between these numbers is likely due to nurses over-reporting the discussion happening and/or patients not recognizing when the conversation is occurring.

Researchers offer diverse reasons for low engagement in ACP by acute care nurses. One of those reasons is that their heavy workload does not allow for uninterrupted time with patients in a private setting to engage in ACP conversations with patients and their decision makers (Rietze et al., 2018; Rietze & Stajduhar, 2015; Schulman-Green et al., 2005). Allen (2014, 2015) also found that the amount of time that nurses were able to spend with their patients during their shifts was limited. These results were supported by other research showing that acute care nurses engaged patients in direct care for

approximately 25% of their work day and spent 75% of their time on indirect patient care tasks such as charting, collecting supplies, and gathering medications (Hobgood et al., 2005). With such a division in tasks, nurses had limited time to engage patients in ACP in acute care settings.

From an organizational standpoint, most acute care organizations lack policies and procedures related to who should engage in ACP with patients, when it should take place, and if it is essential (Baughman et al., 2015; Detering et al., 2021; Martina et al., 2021; Mohan et al., 2020; Rietze et al., 2018). Consequently, nurses are not clear whether ACP is a part of their scope of practice (Putman-Casdorph et al., 2009; Rietze et al., 2018; Vanderhaeghen et al., 2018), they receive limited education, training, and templates on how to engage in ACP (Baughman et al., 2015; Martina et al., 2021; Whitehead et al., 2021), and they are uncertain about how, or if, ACP influences treatment planning in their organization (Duke & Thompson, 2007; Putman-Casdorph et al., 2009).

Research conducted to date provides a good foundation to appreciate the context in which nurses are making practice decisions about ACP with patients. However, there is limited understanding of how larger contextual, social, and organizational contexts of institutions might influence the capacity of nurses to take up an ACP role in acute care settings (Gagnon & Duggleby, 2014; Scott et al., 2003, p. 926). Advancing the idea of ACP in acute care settings must be done with a comprehensive understanding of the culture, discourses, competing interests, and political or public policies that impact nurses' work in the hospital setting. To address this gap in knowledge, the focus of this research is on how acute care organizations shape the uptake of ACP by nurses with their patients.

1.1 Statement of the Problem

Acute care nurses are working in complex organizational structures with processes that may influence how they practice ACP (Vanderhaeghen et al., 2018). To date, literature supports that factors such as a lack of privacy, heavy workloads, unclear roles, a lack of time, and a lack of ACP policies and procedures can influence nurses' uptake of ACP in the acute care setting (Rietze & Stajduhar, 2015), but there is little research exploring how social and organizational structures or processes in acute care settings might influence that uptake. This dissertation research aims to shed light on unit, organizational, and social influences that shape the ACP work of nurses. In a context where advocacy groups and researchers recommend that ACP should be initiated and regularly revised by nurses in acute care settings, it is critical that we understand the institutional factors that are impacting their ability to engage in this work with patients.

1.2 Purpose of the Study

The purpose of this study is to understand how social and organizational contexts shape the ability of nurses to engage in ACP as part of their everyday practice with their acute care patients. The main research question guiding this study is: *How is nursing practice shaped and influenced by the organizational context of acute care, to enable or constrain nurses' efforts in ACP?*

1.3 Definition of ACP

For the purpose of this dissertation, ACP is understood as "a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care. The goal of ACP is to help ensure

that people receive medical care that is consistent with their values, goals, and preferences during serious and chronic illness" (Sudore et al., 2017, p. 821). In other words, ACP[1] is a process to clarify and communicate the patient's values to *prepare* health care providers and SDMs for a time when patients cannot speak for themselves. It does not involve prognostication, medical decisions, or treatment decision-making (Reitjens et al., 2017). ACP is sometimes initiated outside of the hospital setting, but in practice, an abrupt decline in the patient's health status is typically a catalyst for nurses to engage patients in ACP conversations as patients begin to envision death (Sudore & Fried, 2010).

1.4 Significance of the Study

In this study, the focus is on how the practice of acute care nursing is shaped by the organizations in which they work. As noted above, most Canadians still die in acute care settings, but their experience in acute care at the EOL is fraught with challenges related to over and under treatment, caregiver burden, and resource limitations. ACP is one way to enhance patient-centred decision-making about the EOL. Although there is evidence to support that ACP leads to positive outcomes for acute care patients and their SDM, there is limited uptake of ACP by nurses. Advancing the idea of ACP in acute care settings must be done with a comprehensive understanding of the culture, discourses, competing interests, and political or public policies that influence nurses' work in the hospital setting. Such an

[1] ACP is often confused with other EOL conversations. Most commonly, ACP is used interchangeably with goals of care (GoC) conversations and Do Not Resuscitate (DNR) discussions. In contrast to ACP's preparatory role in clarifying and communicating one's values about what an acceptable death might be at the EOL for anyone at any age or stage of health, GoC conversations focus on discussions about medical treatment decisions when the patient is seriously ill. DNR conversations, or more commonly called '*code status*.' are discussions held with seriously ill patients or SDMs and focus on obtaining consent to withhold cardiopulmonary resuscitation in the event of a cardiac arrest.

understanding has the potential to inform organizational policies and processes to better support ACP practices in acute care settings, and ultimately lead to better alignment between patient values and their medical treatment.

Chapter Two: Literature Review

In this chapter, I set the stage for my research by identifying directions provided by nursing professional associations on the scope of practice of nurses in Canada regarding ACP. Next, I review existing literature to identify the state of knowledge related to nurses' engagement in ACP in acute care settings. Finally, I will describe the current state of knowledge about how the organizational context of acute care influences the everyday work of nurses.

2.1 Nursing Position Statements and Recommendations Regarding ACP

Scholars and clinicians have published ACP competency statements to provide guidance to generalist registered nurses on the roles that they are able to fulfill in their practice in Canada (Canadian Association of Schools of Nursing, 2011; Canadian Nurses Association, 2015; Hospice and Palliative Nurses Association, 2011). In a joint position statement on palliative care and the role of the nurse, the Canadian Nurses Association (2015), in collaboration with the Canadian Hospice Palliative Care Association and the Canadian Hospice Palliative Care Nurses' Group, state that registered nurses initiate ACP conversations with patients, honour ACP wishes, and advocate for patient wishes with other health care providers. Also in line with this direction, the Canadian Council of Cardiovascular Nurses states that registered nurses have the responsibility to have meaningful ACP conversations with patients, educate themselves and patients about the legal and ethical implications of ACP, and honour the patient's ACP wishes (Catlin et al., 2015). Internationally, the Hospice and Palliative Nurses Association (2011) offers a position statement to generalist registered nurses, maintaining that nurses identify, clarify, and advocate for their patients' ACP decisions, and act as activists to campaign for ACP

processes and policies in organizations. In the *Palliative and EOL Care: Entry-to-Practice Competencies and Indicators for Registered Nurses (2011)* (Canadian Association of Schools of Nursing, 2011, p. 1.9) guideline, authors state that in all employment settings, nurses communicate and document decisions made by the patient and family members regarding their wishes for palliative and EOL care, but they are not specific to ACP conversations.

2.2 Nurses' Roles in ACP

Although there are many professional position statements indicating that ACP is within the scope of practice of nurses, it is important to understand if this translates into practice. In this section, I review the literature related to the engagement in ACP of acute care nurses. For the purpose of my work, I am interested in reviewing the practice of ACP in acute care settings. However, some studies that explored this topic mixed their data on nurses' ACP practice in acute care settings with data from nurses working in other clinical settings.

2.2.1 ACP Roles in Diverse Clinical Settings

Nurses working in diverse clinical settings occasionally reported engaging in ACP with their patients. Arnett et al. (2016) employed a cross-sectional survey approach to understand the clinical routine of health professionals in diverse settings in the USA. In their study of 118 health care professionals, the majority of respondents (86%) stated that non-physicians had the capacity and the opportunity to play a role in ACP conversations with patients, but 48% felt that their role in ACP was as an informant within interdisciplinary team discussions. In another study, by Dixon and Knapp (2018), interviews were conducted with 157 senior managers, ACP leads, ACP facilitators,

physicians, nurses, social workers, and other staff employed by 12 health care organizations in the USA, Canada, Australia, and New Zealand to better understand the process of developing, delivering, and staffing units for ACP. Findings from this study confirmed that nurses felt they engaged best in ACP as an informant on the interdisciplinary team. In their study, Shanley and Wall (2004) had similar findings, adding that when engaging in ACP within interdisciplinary teams, the roles that nurses typically had were to initiate, clarify, support, advocate, educate, research, and activate ACP plans.

2.2.2 ACP Roles in Acute Care Settings

The state of knowledge related to nurses' roles in ACP in acute care hospital settings is limited. In a qualitative study of nurses' and social workers' experiences in advance directive communication, Black (2006) found that nurses primarily fulfilled the role of educating patients on pragmatic information, such as describing medical interventions and clarifying treatment options in lay language as they pertained to the patient's illness trajectory. Nurses in this study also stated that they were routinely the initiator of the ACP dialogue, the advocate for patient wishes, and they liaised with the SDM. Using a prospective non-randomized controlled trial, Seal (2007) surveyed 160 registered nurses before and after the implementation of a new ACP policy in an acute care hospital in Southern Australia to better understand the role of patient advocacy. In this work, Seal (2007) found that the implementation of an organizational policy normalized ACP as a routine part of the care of patients in hospital settings, and formalized the nurses' role as an advocate for their patients' wishes for EOL care. Fliedner et al. (2021) conducted a scoping review on the roles of acute care nurses in the ACP process. Data from this study supported that acute care nurses identified that they fulfilled the role of advocate, facilitator, and educator related to ACP conversations in the hospital setting. In summary, the

literature supports the view that nurses played a variety of roles in ACP conversations with their acute care patients.

2.3 The Influence of Organizational Contexts on Nurses' ACP Work in Acute Care

Some studies specifically aimed to explore the effect of hospital organizations on the work of nurses' care of patients at the EOL. This literature highlights multiple barriers that nurses experienced in acute care settings as they engaged patients in EOL care and ACP. The most common barriers cited were the need to prioritize medical tasks, a lack of privacy, a lack of organizational processes, the existence of hierarchical relationships, and the focus on treatments and cure within acute care settings.

2.3.1 Needing to Prioritize Medical Tasks

Oberle and Hughes (2001) employed a grounded theory methodology to understand the ethical dilemmas experienced by nurses in their ability to provide EOL care in hospital settings. Findings from this study identified that financial constraints and staffing cutbacks resulted in the need to prioritize medical tasks with patients, which limited their time to engage with patients about EOL conversations. Chan et al. (2018) employed an ethnographic approach to better understand nurses' justification of the prioritization of patient care on a medical unit in one Canadian hospital. In this study, researchers found that nurses had to prioritize their task-oriented medical care of patients in order to manage the demands on their time due to their overwhelming workload. They reported that nurses prioritized tasks in the following way: "first, managing acute medical crises and, second, tangible, biomedical tasks …that were often related to prolonging life" (Chan et al., 2018, p. 457), such as dispensing medication and maintaining lines and tubes. Of lower priority, then, were EOL care tasks and palliative care. In fact, nurses stated that they did not enter the rooms of palliative patients as frequently as their active treatment

patients as there were fewer medical tasks to be performed. In addition, a UK study aimed to explore the thoughts and ideas of nurses working on acute medical hospital units with patients at the EOL, and found that nurses had to prioritize their time on completing medical tasks with patients and consequently did not have time to engage in ACP (Clarke & Ross, 2006). Nurses expressed deep despair as they felt they did not have the resources to listen to patients at the EOL due to multiple competing demands for their time (Clarke & Ross, 2006).

2.3.2 Lack of Privacy

In addition to a lack of time, Clarke and Ross (2006) found that acute care settings offered limited privacy for nurses to engage their patients in communication about EOL values. Findings from another grounded theory study by Thompson et al. (2006) confirmed that nurses felt there was limited privacy in acute care settings, which was cited as a barrier to engaging in EOL conversations with patients, and prevented nurses from providing high quality care at the EOL.

2.3.3 Lack of Organizational Processes

Rietze et al. (2018) used a cross-sectional descriptive survey to sample 125 Canadian nurses to determine the extent to which they engaged their patients in ACP in acute and non-acute settings. Findings from this study supported the above themes that nurses' engagement in ACP was limited by their inability to prioritize conversations with patients, and a lack of private settings in which to engage in ACP. The researchers also found that unclear organizational policies and procedures related to ACP (and corresponding unclear expectations for nurses to engage patients in ACP), as well as rapidly changing clinical assignments, were important barriers to initiating ACP with patients. In a study conducted by Seal (2007), nurse respondents stated that institutions that had an organizational policy identifying a formalized ACP framework had greater engagement in ACP by nurses. In these settings, organizational policy normalized

ACP as a routine part of the care of patients in hospital settings, prescribed which health care provider was responsible for this task, and provided clinicians with a formal process and protected time for ACP (Seal, 2007). In their systematic review, Jimenez et al. (2018) found that institutional and operational contextual elements that limited the initiation of ACP in health care settings were a lack of legalistic paperwork, an absence of electronic medical records to record and share ACP, and limited embedding of ACP into routine care of patients. Similarly, a study by Detering et al. (2021) found that organizations that successfully engaged in ACP were those that supported ACP programs integrating these discussions into the daily care of patients.

2.3.4 Hierarchical Professional Relationships and Organizational Power of Nurses

In an ethnographic study, Baggs et al. (2007) observed and interviewed physicians, nurses, and social workers to understand the unit culture surrounding advance directives of medical treatments at EOL in four different intensive care units in the United States. Findings from this study supported the above premise that organizational processes influence the work of clinicians in that health care providers adapted their practice to be consistent with informal unit-specific expectations, definitions, policies, and procedures related to EOL conversations (Baggs et al., 2007). However, this study also supported that hierarchical professional relationships and organizational power were barriers to nurses' ability to engage in EOL communication with patients as they felt that their clinically oriented position in the hierarchical structure of hospital settings did not render sufficient organizational power to control their own practice choices (Baggs et al., 2007). Instead, they felt that other professions had an impact on organization-wide formal rules and unit-based informal rules that influenced the practice on hospital units. Similarly, Vanderhaeghen et al. (2018) employed a grounded theory methodology to study 24 acute health care providers in Belgium, and found that the most common organizational barrier

to engaging patients in ACP was power struggles within the hierarchy of health care providers. Findings from this study indicated that physicians were key to initiating ACP, and they also had decision-making authority related to who could hold these conversations with patients and families. Such relationships left some respondents feeling powerless to help patients with EOL decision-making in their setting.

2.3.5 Treatment and Cure Focus in Acute Care

The 'cure'-focused culture in acute care settings has also been cited as a barrier that prevents nurses from engaging their patients in high quality EOL care, including ACP. A grounded theory study by Willard and Luker (2006) examined the challenges to hospital-based EOL care from the perspective of nurse specialists in the UK. Nurse respondents reported that the most significant challenge to quality EOL care discussions in the acute care context was the preoccupation with treatment and curing illness. Consequently, nurses felt that the focus on treatment and active medical care was prioritized over preparing patients and families for EOL. Thompson et al. (2006) had similar findings in that nurses found it difficult in the acute care setting to provide quality EOL care, particularly when the trajectory of the patient was unclear. The idea that acute care settings are fixated on curative treatments may be related to the above theme of having to prioritize medical tasks in one's clinical acute care practice and forgo EOL conversations with patients.

In summary, research related to the impact of organizations on nurses' care of patients at the EOL, and the engagement in EOL decision-making, supports that there may be some elements of the organization that influence nurses' practice. Most commonly, studies found that acute care organizations posed barriers to nurses' ACP work with patients in the following ways: nurses needed to prioritize medical tasks, acute care units had a lack of privacy for patients,

institutions had limited organizational processes and policies that supported ACP, hierarchical structures diminished the organizational power of nurses, and acute care settings were focused on curative treatments, not EOL communication. Even so, there is a gap in the literature on how social, organizational, and unit level factors have an impact on nurses' engagement in ACP practice (Detering et al., 2021).

The purpose of this study is to understand how social, unit, and organizational contexts shape the ability of nurses to engage in ACP as part of their everyday practice with acute care patients. The research question guiding this study is: *How is nursing practice shaped and influenced by the organizational context of acute care to enable or constrain nurses' efforts in ACP?* The specific aim of this study is to examine the wider social and organizational structures and processes that constrain and facilitate nurses' engagement in ACP on acute care units.

Chapter Three: Nursing Practice and Advance Care Planning

In this chapter, I start by describing the essence of my interest in the research question: *How is nursing practice shaped and influenced by the organizational context of acute care to enable or constrain nurses' efforts in ACP?* There are three elements that are of particular interest to me. They are: 1) how nursing practice shapes and is shaped by acute care hospital care delivery, 2) how acute care hospital care delivery organizes ACP and is organized by that context of care, and 3) how nursing practice, health care delivery, and ACP can be understood as an organized, concerted set of practices.

To start, my interest in how nursing practice is shaped comes from my experience as a nurse educator. In my role as an educator, I am actively involved in teaching students nursing skills, practices, and behaviours that are consistent with their scope of practice. Yet, as students are exposed to the clinical setting, they often adapt their practice to fit with "the way things are really done" in practice. The theory-practice gap is well documented in the nursing literature (Gassas, 2021; Saifan et al., 2021; Strouse et al., 2018). I am intrigued to learn more about the enculturing factors that shape nursing practice. Some of these "multifaceted influences to the culture of nursing" (Strouse et al., 2018, p. 24) may be the enculturing process, health sector legislation [i.e., the Public Hospitals Act (Ontario Ministry of Health and Long Term Care, 1990)], or structural and systemic factors of organizations. There is little known about how the structure or system of organizations might impact nursing practice.

Further, as seen in the previous chapters, researchers, clinicians, and policy makers advocate that ACP is consistent with patient-centred care and advantageous for patients, their families, and health care providers, yet we know that ACP is not a routine part of nursing

practice in acute care settings. There is some preliminary work reviewed above that begins to question if there are systemic and structural issues within the acute care setting that introduce overwhelming barriers to nurses' engagement in ACP with their patients. I am interested in employing a methodology that will help me to understand the contextual and organizational factors that limit ACP practice by acute care nurses.

I am looking to better understand the concerted features of modern health care delivery and the practices therein. To unpack this further, I am interested in how nursing practice, health care delivery, and ACP might be organized in the social world of acute care settings. In these social settings, factors that make certain practices more likely and others less likely (beyond that of general acceptance that a practice is advantageous or patient centred) are of particular interest.

My interest in organizational culture informed my decision to employ ethnography as a methodological choice to generate research materials I could analyze to answer the questions posed in my study. My interest in carefully examining the practices of nurses and how those produced and reproduced recognizable cultural patterns meant that I also needed to draw on a philosophical approach that could help me understand the relationships between practices and cultural patterns. In the section that follows, I provide further detail on the choices of methodological and philosophical grounding that supported me in my work of understanding these complex relations.

3.1 Methodology

Based on the literature review presented in the preceding chapter, there remains a gap in knowledge on how social, organizational, and unit level factors have an impact on nurses' engagement in ACP practice. In my introduction to this chapter, I offer further evidence for the relevance of this inquiry based on my own professional experience. In order to address my

questions, I sought a methodology that would enable me to understand the social and cultural meanings of nurses' practices as they engaged in their everyday work in acute care settings. Ethnography offered a methodological context that would enable a study of practices embedded in a specific social context (Clifford & Marcus, 1986; Geertz, 1973; Gubrium, 1988, pp. 24, 26).

Bronislaw Malinowski is considered by many to be the father of ethnography. Malinowski conducted ethnographic research adopting a realist approach to writing and an uncritical approach to data collection. In the 1920s, Malinowski lived amongst the Trobriand Islanders, the Indigenous peoples of New Guinea. He generated ethnographic accounts of their daily lives, behaviours, and beliefs (Malinowski, 1922). In his work, Malinowski aimed to document cultural and social structures, process, and situations that existed, as he thought about it, independent of his influence. There have been many critiques of this position as it arises in ethnography, as well as many other areas of the physical and social sciences (Denzin & Lincoln, 2011). Perhaps the best-known critique of the realist position is found in the collected essays presented by Clifford and Marcus (1986). In these collected essays, the authors challenged the idea that ethnographers have a totalizing gaze, and contested the representation of ethnographic findings by arguing that the ethnographer should be understood as the research instrument. Atkinson et al. (2011) state that around this time, ethnographers experienced an *interpretive, linguistic, or rhetorical turn (also known simply as 'the turn').* This representational crisis had two main contestations. Proponents questioned the impact of the ethnographer on their accounts and analyses in that they challenged the assumption that researchers could separate themselves from what can be known about the other (Wolcott, 1990). Instead, scholars postulated that interpretations of what was observed, heard, and read about in the other culture could only arise through the interpretative capacities of the observer (Wolf, 1992). 'The turn' was also characterized by an enhanced

awareness of the interpretive construction, use, and management of ethnographic field notes (Atkinson et al., 2011). As a result, 'the turn' generated a number of new types of ethnography, such as institutional ethnography, where researchers position their work within a feminist philosophy and the primary source of data is textual (Smith, 1987), and critical ethnography, with a purpose of addressing social injustice and inequity to inform social change and liberate people (Carspecken, 2001).

Although there is no universally accepted definition of ethnography, it is generally understood as a methodology used to explore social or cultural contexts using first-hand experiences (Geertz, 1973; Hammersley & Atkinson, 2007). There are broad family resemblances between the various forms of ethnography. The most common method for collecting data in ethnographies is observation of a small number of participants in natural, everyday settings (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 2007; Roper & Shapira, 2000a). In addition to fieldwork, ethnographies use other methods of collecting data, such as conversations, interviews, and textual materials to gain insight into events, behaviours, and relationships (Atkinson et al., 2011). Traditionally, the outcomes of an ethnographic study are narrative thick descriptions, explanations, and/or theories of the observed phenomena (Atkinson & Hammersley, 1994; Hammersley & Atkinson, 2007; Roper & Shapira, 2000a).

3.2 Application of Ethnography in this Study

In this study, I was interested in understanding how organizational contexts shaped nurses' ability to engage in ACP as part of their everyday practice with acute care patients. This study was well aligned with ethnography in that I wanted to explore the organizational context as a social phenomenon, and the decision-making process of its people within their context of everyday work (Denzin & Lincoln, 2011). Ethnography also allowed me to employ multiple data

collection methods to observe the behaviour of nurses on the units and understand the tacit complexities of their decision-making impacting their ACP practice. In this way, I was able to gather information on a particular culture within a broader social context, and better understand the nurses' emic point of view (Spradley, 1979; Spradley, 1980).

Ethnography was also an appropriate methodology for pursuing this topic because it allowed me to use my insider knowledge of acute care nursing to focus the data collection to the situations, interactions, units, and moments in which ACP may occur. Headland et al. (1990) support the idea that a researcher with an emic perspective may be able to immerse himself or herself into the culture to be studied to a greater extent than one with an etic viewpoint. For instance, some of the participants knew me personally, so they were more open to sharing their perspective because they felt they could trust me. This positively influenced recruitment, increased participant comfort during observation periods, and encouraged honesty and candidness during interviews. As a registered nurse who previously worked in acute care settings, I was able to relate to the participants' work environment, yet I could challenge how their understandings were similar or different from my own by asking reflective questions like "*What is happening here and why?"* through the use of interviews (Higginbottom, Pillay, & Boadu, 2013; Roper & Shapira, 2000, p. 3). I found that some participants approached the organization of their nursing work in ways that were very different from the way I did. For example, I learned through observation and interviewing that some participants organized their nursing tasks by prioritizing their importance to the patient's health outcomes, while others were concerned about completing tasks before physicians made their rounds. One nurse spoke of how she distributed morning medications before assessing dressings or pain levels because their routine medications were coordinated with their patient's meals or activity levels. Identifying

such differences between the work of participants and my own experiences was a helpful reminder of the critical distance between our practices. Additionally, during the data analysis and writing phases of this study, I tried to keep it front and centre in my frame of reference that *it could all be otherwise.* This helped me to maintain a critical distance from the data because I was able to consider the description of the participants as only one way that the system could work. Perhaps it was not *the* way it *had* to be.

To be sure though, my positionality in this study was a delicate balance between the "rigidity of these boundaries [of insider and outsider]… and the fluidity of these boundaries" (Halstead, 2001, p. 307). On the one hand, some participants treated me as an insider and thought I was "adept of the culture" (Halstead, 2001, p. 311) that I came to study, and should know the answers to the questions I was asking because I, too, was a nurse who may have worked with them in the acute care setting. On the other hand, some participants saw me as an outsider in that I was not a worker on their unit or in their organization. Halstead (2001) referred to this perspective as a "halfie" or an "indigenous fieldworker" (p. 310).

3.3 Philosophical Paradigm

The critical perspectives of Foucault provided a window through which I could look into my data in order to more clearly see how nursing practice, organizational context, and acute care settings worked in concert to influence ACP practice.

Although Foucault rejected the categorization or *reductive labeling* of his work into one philosophical orientation or another, his work had close ties to critical post-structuralism in that he explored the genealogy of the unconscious structures underlying culture, knowledge, society, language, and the effect that they had on people. He believed that people were co-constructors of the entities and forces that surrounded them, and these forces served specific purposes for groups

of people. His analysis of how cultural practices, power, and policies of institutions governed and organized the conduct of its members was called *governmentality* (Foucault, 1978, p. 220). Foucault suggested that the concerted action of these contextual factors on people might help to illuminate why they make certain decisions, empowering them to challenge the forms of order to ask why they exist, and reflect on if they should be changed. He felt that when these structures and systems that imposed order on society and people were not explored and challenged, they often led to fixed and perpetuated forms of social injustice and ignorance.

The study of culture was also at the heart of Foucault's work because he was interested in how humans imposed order on the world via their social structures and knowledge, and how order breaks down or changes with the passage of time. In fact, he referred to his work as "an analysis of the cultural facts characterizing our culture" (Foucault, 1967, p. 91). He focused on culture because he believed that culture provided a temporal snapshot of how society constructs and organizes knowledge, but it was also a medium through which social relations defined particular behaviours and knowledge as either acceptable or unacceptable. Foucault believed that each time period had a historical imprint on knowledge that was constructed within the context of historical rules, epistemological fields, and political or social powers of the time. Consequently, Foucault advocated that it was essential to examine the relationship between knowledge and the factors that produced and constrained it, because different periods of history organized their formal systems of knowledge according to different epistemes/philosophies (Foucault, 1966; 1978, p. 54).

The work of Foucault helped me to make sense of the data in this study as it provided a theoretical framing to understand the data in different ways, using themes and areas of interest proposed by Foucault. My focus in this study, *how social and organizational factors of acute*

care settings shaped nurses' ACP practice with patients, was aligned with Foucault's interest to understand the ways in which organizations might have influenced the practice of workers and, in turn, how the practices of workers may influence the organization of care delivered within those settings. Foucault's most useful lenses for understanding how organizations shape nurses' ACP practice were:

1. His recognition that individuals are ruled and controlled in a society (Burbank & Martin, 2009; Foucault, 1975, p. 184) by bending "subjects to a single uniform mass" (Foucault, 1975, p. 170) "in order to obtain an efficient machine" (Foucault, 1975, p. 164). This prompted the following question that I asked of the data: *What are the forms of order, structure, and influence impacting nurses' work and impacting their capacity to engage in ACP?*
2. His interest in the genealogical analysis of institutions and policy to illuminate the wider contextual, institutional, and social factors impacting the knowledge and behaviour of workers. This prompted the following questions that I asked of the data: *What are the systems and structures at play? Who do they serve and what are their effects? What is the effect of the language that is being used? What are the organizational values-of-the-day that are organizing this setting, and what is their effect on workers? Who is being served by the organizational values-of-the-day? What is the effect of the language nurses are using and how they are describing their work?*
3. His historical perspective that policy and power within a society has an influence on the organization of cultures. This prompted the following questions that I asked of the data: *What are the temporal factors that are organizing acute care organizations in society?*

What are the beliefs about knowledge, patient care, and resources? What are the intersections and divergences amongst these?

Originally, I anticipated that the outcome of this study would be how to empower nurses and inform organizations about how they might be able to modify their structures to enable ACP in acute care. With the application of Foucault's lens to the data, I was able to see that findings from this study may be more genealogical to illuminate the social and organizational factors that govern nurses' work in these settings.

3.4 Research Design

The following sections define the sample, setting, ethical review, and entry into the setting.

3.4.1 The Setting

In order to protect the identity of the participants and gather the diverse experiences of acute care nurses working on different types of units, two separate hospitals served as the setting for data collection. Both hospitals were located in more densely populated centres within predominantly rural small towns. The patients receiving care in both settings lived either in the immediate urban area or in one of the surrounding rural communities. These two hospitals were chosen because the hospital administrators had a willingness to be involved in the study. Pragmatic considerations such as distance to travel, and number of in-patient acute care beds, were also taken into account in site selection to ensure viability of the study in addressing the research question.

The primary hospital site was a teaching hospital[2] and it serviced approximately 560,000 people over a catchment area that was 300,000 km^2 in size. At the time of this writing, there were

[2] Teaching hospitals are sites that participate in the education of medical practitioners, nurses, and other health professionals in Canada.

22,175 patients admitted annually to this health centre, 75,469 patients who visited the emergency department, and 909 deaths in 2020. This hospital was responsible for leading regional programs in the areas of cardiac care, oncology, nephrology, trauma, and rehabilitation. The primary site had 462 acute care beds and 3,907 employees.

Located approximately 90 minutes away by car (141 km) from the primary site, the secondary site was not a teaching hospital and it served approximately 129,000 people. In 2020, there were 8,347 patients admitted to this health centre, 45,570 patients who visited emergency, and 386 deaths. The secondary site had 389 acute care beds and 2,300 employees.

Within the two hospitals, the sample was recruited from a medical/palliative unit (Unit A), a cardiology unit (Unit B), and an oncology/palliative unit (Unit C). See Appendix A for the recruitment poster. The primary site had two data collection units (Units A and B) and the other one served as a "secondary site" (Unit C). Unit A was a 52-bed, in-patient acute medical unit within a university-affiliated teaching hospital located in an urban area of Northeastern Ontario in Canada. This unit received approximately 1,036 admissions per year with an average length of stay of 9.9 days. It was designed as a medical treatment in-patient unit typically admitting patients with pulmonary, cardiac, renal, liver, endocrine, and oncological disease. Unit B was a 53-bed in-patient acute cardiology unit within the same university-affiliated teaching hospital in Northeastern Ontario. This cardiology unit received approximately 2,778 admissions per year with an average length of stay of 7.4 days. Six years prior to data collection for this study, the manager of Unit B volunteered the setting to be a pilot site to test out the introduction of ACP in their organization. The pilot ended 2 months later due to lack of resources. Unit C was a 32-bed, in-patient acute medical/palliative unit within a community-based hospital in a rural area of

Northeastern Ontario. This unit had an average length of stay of 30 days. The patient population were those with chronic pulmonary, cardiac, renal, liver, endocrine, and oncological diseases.

3.4.2 The Sample

The sample for this study were registered nurses who worked on one of the designated units (see Appendix B for email invitation) and organizational administrators (unit managers and members of the senior management team) who oversaw the operation of the study units (see Appendix C for email invitation). Other criteria to participate were that individuals were required to communicate in English and consent to the research study. The study sample was 14 registered nurses (see Appendix D for the demographic data collection form for registered nurses) and 9 administrators (see Appendix E for the demographic data collection form for administrators). Table 1 describes the demographic profile of the study participants. See Appendix F for the consent form used with registered nurses and administrators (Appendix G).

Table 1. Demographic Profile of Sample

Registered Nurses (n=14)	
	Mean (range)
Age, year	41.1 (26-54)
Number of years since registered nurse graduation	12.5 (2-27)
	n (%)
Sex	
Male	1 (7.1)
Female	13 (92.9)
Other	0 (0.0)
Highest level of education completed	
Diploma	5 (35.7)
Undergraduate degree	8 (57.1)
Graduate degree	1 (7.1)
Additional courses in palliative care	
Yes	4 (28.6)
No	10 (71.4)

Use of ACP in personal life (outside of their employment)	
Yes	7 (50.0)
No	7 (50.0)
Number of years worked on unit	
0-3 years	3 (21.4)
4-7 years	4 (28.6)
8-11 years	2 (14.3)
12+ years	5 (35.7)
Estimated number of patients/week at EOL	
0	1 (7.1)
1-2	8 (57.1)
3-4	5 (35.7)
4+	0 (0.0)
Typical shift worked	
Days	4 (28.6)
Evenings	0 (0.0)
Nights	0 (0.0)
Mixture	10 (71.4)
Administrators (n=9)	
	Mean (range)
Age, year	55.8 (52-60)
Number of years worked in organization	24.9 (1-33)
	n (%)
Sex	
Male	1 (11.1)
Female	8 (88.9)
Other	0 (0.0)
Highest level of education completed	
Diploma	3 (33.3)
Undergraduate degree	3 (33.3)
Graduate degree	3 (33.3)
Discipline of formal training	
Nursing	8 (88.9)
Other	1 (11.1)
Number of years administrator on unit	
0-3	2 (22.2)
4-7	3 (33.3)
8-11	2 (22.2)
12+	2 (22.2)

3.4.3 Entry into the Setting and Ethical Review

Negotiating access to the field was a multi-step process of negotiation and renegotiation (Jorgensen, 1989). Prior to beginning the ethics application process, I met individually with the Administrative Medical Directors of the primary and secondary sites and provided them a summary of the study. Both of the administrators were supportive of the study and sent emails to the unit managers to introduce the study, asking them to make time to meet with me to support recruitment. Ethical approval for the study was obtained from the University of Victoria's Human Research Ethics Board, the harmonized Research Ethics Board of Laurentian University and the primary site, and the Research Ethics Board of the secondary site. Next, the manager of each of the units was contacted to explain the study. In particular, managers were concerned that the study would increase the workload of nurses, jeopardize the safety of patients, and interrupt the work on their unit. I assured managers that the study would not increase the workload of the nurses, nurses would not be required to ask patients for consent to the study, and patients would not be interviewed or observed. I asked managers how I might best invite nurses and administrators to participate in the study. Upon their suggestions, the following strategies were used to recruit participants for this study:

1) The study description and poster were emailed to all staff and administrators on the unit by the unit manager.
2) The study poster was displayed on each of the units (in the washroom, break rooms, and workspaces).
3) Daily onsite observational periods were aimed at rapport building and coffee/snacks were provided to staff.
4) Increased flexibility for data collection times/formats were offered.

5) The researcher's text number was added to the study poster to enable interested respondents to ask questions about the study with ease
6) Snowball sampling.

3.5 Methods

During data collection, ethnographers primarily collect unstructured data from multiple sources using ethnographic techniques of observation, formal and informal interviews, field notes, and document analysis in order to compare and contrast data, check inferences, and triangulate information (Hammersley & Atkinson, 2007, p. 102). In accordance with this, my study used multiple distinct data sources. The main method for collecting data was observations in naturalistic settings while asking questions such as *What is going on here?* (Roper & Shapira, 2000b). Field notes and memos were written based on observational experiences. In addition, semi-structured interviews with participants were conducted and relevant documents were reviewed. However, none of these data sources were considered more epistemologically informed, privileged, or advantaged over others (Haraway, 1988; Harding, 1993).

3.5.1 Observation

In this study, I fulfilled the role of observer (Burgess, 1984; Gold, 1958). My role in observation was to watch, listen, ask questions, and *learn the ropes* in order to acquire a sense of the ways in which nurses choose to engage patients in aspects of ACP, and learn the social structure and functioning of the unit. Observational data came from being present in the nursing station, attending unit rounds, shadowing registered nurses as they worked, and attending meetings (see Appendix H for the Ethnographic Observational Guide for Meetings). In prioritizing patient safety, I did not participate in patient care. Data collection began by shadowing or buddying with participants while they engaged in their regular duties on units A,

B, and C. In line with ethnography, observation was the main data collection method (Higginbottom et al., 2013; Knoblauch, 2005). The aim of these observational blocks was to "grasp basic issues in everyday social life and [their] routine conduct" (Atkinson, 2015, p. 12), gather "answers to contextual questions that cannot be answered by interview alone" (Morse & Field, 1995, p. 105), and learn about the social structure and functioning of the unit. In addition, observational data helped me to understand the nuances of nurses' work and interpret interview and document data in the study (Funk & Stajduhar, 2009; Roper & Shapira, 2000a).

I began observing in unit A and B in the primary site. In line with recommendations from Hammersley and Atkinson (2007), I observed for 4 hour blocks of time during weekday/ weekend, day/night/evening shifts. I stopped observing at 4 hours because I was tired. When I started observational hours, I took note of everything I experienced because I did not know what I was looking for in this setting and I did not want to miss anything. I captured data about the environment, patients, nurses, visitors, patterns of behaviour, staff comments, and the flow of a shift. Eventually, I was not able to keep up with recording this level of detail, especially when the unit became busier (admissions, discharges, emergencies, mornings), so I refocused on the research question and purpose. During observational periods, I needed to regularly remind myself to *ask* participants *why* activities were happening on the unit, or why they were practicing in certain ways, in order to avoid making insider assumptions while collecting data in these settings. In fact, at the top of my field notes book, I routinely wrote the work 'ASK' to remind myself to inquire about the meaning behind my observations. It was also during data collection that reflexive journaling became a regular tool that I used to keep track of my knee-jerk reactions to observations and interview data while reflecting on my relationship with what I was seeing.

While engaging in observation, discussion with and amongst the respondents naturally occurred, and informed my analysis of data in response to the research question. It was through this method that I learned about the organizational and unit-based values, rules, and typical expectations in each of the settings as perceived by the participants. These interviews proved to be helpful to explain or contradict actions taken by participants (Roper & Shapira, 2000a). The informal interviews were not pre-arranged. I asked clarifying questions about events or practice decisions that were made on the unit to better understand their perceptions. Some clarifying questions that I asked during the informal interviews were: *I noticed that there is a flow to nurses' work on the unit. For instance, most people do X, then XX, and XXX. Can you tell me how you decide this? How could a nurse's work be described on this unit? Can you tell me about how you decide on what you would ask this patient?*

Once I had some initial observations in the primary site, I began observational blocks in the secondary site. After collecting at least 8 hours of observational data in each of the three units, I also began to conduct semi-structured interviews so that I could complement the observational fieldwork with interview questions and listen for the factors influencing participant decision-making and practice. The iterative collection of data (observational fieldwork data, informal interviews, and semi-structured interviews) and initial stages of analysis helped me to validate observations made during fieldwork, provide direction for future fieldwork, and gather data on tacit feelings and reasoning related to their practice decisions (Higginbottom et al., 2013; Roper & Shapira, 2000b). After these initial observational hours and interviews, I began to focus on key events and incidents related to nurses' practice decisions, ACP implementation, and how acute care settings, nursing practice, and ACP worked in concert on the unit (Emerson et al., 1995). I continued in this fashion of collecting data from multiple methods complemented by

intermittent periods of data analysis to reflect on what I was hearing and seeing, what I was learning, and which study themes needed further clarity and development. In total, I completed 20 observational hours on each of units A and B (primary site), and 10 hours on Unit C (secondary site). See Appendix I for my fieldwork calendar. It was my intention to spend more than 50 hours of observational time in the field, but due to COVID, acute care settings in Ontario were closed to researchers and students in an effort to reduce the risk of viral transmission to patients.

3.5.2 Field Notes and Memos

According to Clifford (1990), field notes are "basic processes of recording and constructing cultural accounts in the field" (p. 52). Although there are no universally accepted templates for field notes, I began to write them as "inscription notes" (Clifford, 1990, p. 51) on a notepad for the purpose of quickly recording an observation, or a word/phrase someone used (Appendix J). Following each observational shift, inscription notes were fully described into what Clifford (1990) called "transcription notes" (Appendix K). These notes included my more developed notes of observational data, such as the physical setting, actions that occurred, as well as verbal and non-verbal behaviours (Morse & Field, 1995), and my evolving interpretations of the data, such as my thoughts, insights, and decision trails about the data that, combined with initial coding, led to the development of patterns and concepts (Bernard, 2001). These notes were helpful in that they often formed the basis of questions that I explored in subsequent interviews, observations, or documents. Initially, field notes were quite broad and purely descriptive, but as observation progressed, commonalities and relevant themes in the data began to emerge so that they became more analytic and focused on the research question. Transcription field notes were then followed by what Clifford (1990) called "description," which is where I developed what

Geertz (1973) called “thick descriptions” (Appendix L). I used the descriptive field notes in the data analysis stage. I also recorded memos (Appendix L) to capture my feelings and initial reactions to the data. Lipson (1991) states that keeping notes of one’s knee-jerk reactions to observations and interview data is a helpful way of “checking in and noting what is occurring inside, what one is responding to, and seeing if relations are interfering with what is being observed” (p. 85). I used memos to identify personal reactions and assumptions that I had related to this topic area and the data. Some of the memos in this study were feelings of surprise, comfort, anxiety, and shock that helped me to reveal my assumptions of what nursing was, and how I thought practice was governed in acute care settings. Memoing data was used in this study to facilitate my reflexive thinking and keep track of how I might be influencing the data as a researcher and as a nurse myself. Some of the memos I wrote were my reflections of observations, my biases, professional and social positioning, participants’ reactions to me as an observer, dynamics of my relationship with participants, description of my personal feelings/interpretations based on the observation, and questions that I might follow up with in subsequent interviews.

3.5.3 Formal Semi-Structured Interviews

In-depth, semi-structured interviews were used to contextualize and complement data generated from other sources. Formal semi-structured interviews were pre-planned based on an interview guide (Appendix M). The questions were used as a tool to guide the conversation with various probes designed to elicit information of respondent experiences and insights. The interview guide consisted of an initial overarching question related to the research question and purpose of the study.

This type of interviewing was followed by specific descriptive, structural, and contrasting questions to further focus the data collection[3]. Formal interviews were recorded for transcription and analysis (Higginbottom et al., 2013). Fourteen registered nurses and nine administrators consented to an interview. All of the 60-90 minute interviews occurred in person or over the phone at a time and location that was convenient for the respondent, while respecting confidentiality and safety for the participant and the interviewer. As stated above, I collected data from multiple sources in an iterative, concurrent fashion with intermittent periods of analysis. Once I completed five interviews, I began to review the data and relate it to that from other sources to generate initial thematic conceptions of the data (Hammersley & Atkinson, 2007). Following each interview, transcriptions were made of the recording and I also wrote a summary of what I thought the essence of the interview conveyed. These summaries were helpful in establishing early findings and informing subsequent rounds of data collection.

3.5.4 Documents

The collection of documents occurred simultaneously throughout the study. Existing organizational documents such as policies, procedures, strategic plans, posters, as well as accreditation documents, were selected as supplemental data where appropriate and taken into account to support primary data sources, interpretations, and analyses (Appendix N). Hammersley and Atkinson (2007) agree that documentary sources are useful to understand the influence of the social world on behaviour because "documentary sources construct facts, records, diagnoses, decisions, and rules that are crucially involved in social activities" (p. 121). No patient charts were reviewed and no emails were copied.

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[3] Such as, "I am aware that your unit was involved in a pilot project related to ACP in the past and it ended. Can you talk about how your work and hospital environment is the same or different compared to that time?"

3.6 Data Interpretation and Analysis

Thematic analysis of transcribed field notes, interview transcripts, and documents were completed by the constant comparative method to create a composite description of the social organization of nursing practice within acute care organizations. The analysis of primary data in an ethnographic study typically involves interpretation of the meaning, function, and consequence of human actions in one's culture (Atkinson & Hammersley, 1994, p. 248; Hammersley & Atkinson, 2007). To do this, I began asking Foucaultian questions of the data, such as: *What are the systems and structures at play? Who do they serve and what are their effects? What is the effect of the language that is being used? What are the organizational values-of-the-day that are organizing this? What is the effect of this approach on people? Who is this approach serving? What is the effect of the language nurses are using and how they are describing their work? What are the temporal factors that are organizing acute care organizations in society? What are the epistemological fields of this period that impact nursing practice in hospital settings? What are the beliefs about knowledge, patient care, and resources? What are the intersections and divergences amongst these? Why do these forms of order, structure, and discipline exist? Should they be changed?*

The aforementioned questions were helpful because they focused my analysis through Foucault's lens of governmentality in order to see how nurses' practice was shaped in the acute care setting. It also helped to identify where I needed to collect more detail in the next round of data collection. Generally, analysis of ethnographic data requires the researcher to break up the data into small bits and then reassemble them into patterns or wholes (Wolf, 2012). In this ethnographic study, the process of data collection and data analysis was iterative in that collection and analysis were conducted concurrently (Hammersley & Atkinson, 2007). During

the iterative process, constant comparison of the existing data and subsequent areas for data collection allowed for flexibility in the data collection to expand on emerging concepts, and enabled me to ask more detailed questions during subsequent rounds of collection (Carter & Little, 2007). Higginbottom et al. (2013) agreed that an ethnographic analysis should be an iterative, cyclical, self-reflective process as preliminary interpretations could be challenged, and data can be revisited in subsequent phases of data collection. To assist in data analysis, NVivo was used for the purpose of categorizing, organizing, and retrieving data during the process of collapsing or comparing codes.

3.6.1 First Level Coding: Descriptive Codes

First level coding was used to condense and reduce the data (Miles et al., 2014). During this step, I transcribed interviews, wrote field notes, created memos, and reviewed documents, and during these processes I noticed similarities in the data. I also reviewed each of the summaries that were generated from the interviews. As I read and re-read, I reflected using questions like: *What is this?* or *What is going on here?* As I conducted this preliminary analysis, I saw patterns of shared meaning united by a central concept in the data sources. When this happened, I assigned a code to the pattern of shared meaning that best described it (Braun & Clarke, 2013). Once I had some preliminary descriptive codes, my supervisor and I worked on a selection of study data and independently generated codes in this same way. We then met and found that we had general agreement in our early descriptive codes, and together we organized them into what we called *big buckets* or, as LeCompte and Schensul (2010) refer to it, *chunking the data into bins*. These big bucket descriptive codes were not fully developed ideas, but they served to assess and capture emergent ideas that were immediately evident from the data to aggregate similar or related items into groups (Roper & Shapira, 2000). Some of the initial big

buckets descriptive codes were: relevancy of resources, barriers to ACP, complexity of nurses' work, when to engage in ACP, legality of ACP, organizational processes, strategic directions, efficiency, alternative-level-of-care (ALC), evaluation of acute care, and patriarchy.

To generate descriptive *big bucket* codes, I first read and re-read data from all sources, attending to patterns of shared meaning amongst the data sets, and then I assigned a code to this pattern that best described its central concept. For instance, I reviewed the strategic planning document of the organization (strategic plans were: a patient and family focus, digital enabled, socially accountable, support and develop our people, and strengthen our academic and research impact). This was a helpful perspective from which to understand the goals of the health care setting. In my interview data, one participant described how their strategic plan has an impact on their work:

> We have a work-plan that has laid out some key milestones that we can deliver in each year of the 6-year strategic plan and then on an annual basis, we work that into sort of more detailed plans of what we are going to do for the given calendar year and set aside funding within our operating budget to help support the implementation of those plans.

Taken together, these data were assigned to the descriptive code of strategic direction. Using another example, documents and processes such as Accreditation Canada's standards and the Public Hospitals Act were reviewed, in addition to the re-reading of interview and observational data. One nurse participant spoke of how accreditation standards impacted their organizational processes:

> There has been a lot of tasks that have fallen to us and it seems like even with the new accreditation standards and changes in pharmacy, now we have CMARS and they are trying to create efficiencies in other departments, but then it causes more work and challenges for us.

Observational data were also reviewed and the presence of accreditation charts, foci, and standards were posted on the unit's corkboard. This second bunch of data was assigned to the descriptive code of organizational processes.

3.6.2 Second Level Coding: Identifying Patterns

Similarly to first level coding, I sorted and grouped the descriptive codes (big buckets) into common topics and patterns, and began to identify not only similarities and differences within the codes, but also relationships between them (Hammersley & Atkinson, 2007). This step included the collapse of similar codes and the differentiation of others. For instance, the two descriptive codes (and associated data) above were collapsed into one code: *organizational processes and directions.*

It was at this point that I began to write up the findings. The process of writing was very helpful in my analysis as I continually reflected on *What themes am I beginning to identify that relate to my research question?* This was a difficult question as I had so much data that I wanted to write about everything, even if it did not relate to my research question. As I wrote, I saw that the descriptions of some codes were very similar so I was able to further collapse, differentiate, and re-define drafted codes during this step. As a result, the final second level codes were: Understanding the Context of Acute Care Nursing Practice, Organizational and Operational Issues Imposing Order on Acute Care Nurses' Advance Care Planning Work, Understanding the Context of Acute Health Care Settings. These codes are also referred to as themes.

3.7 Methodological Rigour

Establishing rigour by verifying the data and validating the conclusions of research studies is an essential component in any research project. Quantitative scholars argue that the subjective nature of qualitative research raises issues with methodological rigour (Morse, 2018), suggesting

that it is impossible to remove the observer from research in naturalistic settings (Wadams, 2018). My subjectivist epistemological approach to this study concedes that the researcher cannot remove their influence in data collection or analysis. Consequently, the goal of this study was not to obtain an objective "truth" that was generalizable to all nurses. Instead, I offer the findings of this study as an *interpretation* backed by data. To this end, verification strategies that were built into each step of the qualitative research design of this study were undertaken to enhance rigour, including methodological coherence, triangulation, independent review of data analysis, reflexivity, establishing a rapport, and saturation.

3.7.1 Methodological Coherence

Carter and Little (2007) argued that in order to ensure methodological coherence and internal consistency in qualitative research, the theoretical perspectives informing one's research question must be aligned with the epistemological assumptions of the methodological tradition. These and other researchers (Kramer-Kile, 2012; Richards & Morse, 2013) state that internal consistency is important in a qualitative study as it provides clarity to the objectives and the tasks of the researcher, promotes epistemological trustworthiness of the study findings, and increases methodological coherence/rigour. The internal consistency of this study was high in that there was coherence between my research question (to understand how social and organizational contexts shaped nurses' ACP practice), philosophical tradition (Foucault), methodology (ethnography), and methods (observation, interviews, document analysis) because they involved congruent ways of thinking. These aspects share the assumptions that there are overt and covert macro processes that are at work, socially organizing people in institutions, and that investigating these processes requires multiple data sources. Also, internal consistency in this study was high as evidenced by the linkages between the Foucaultian philosophical lens of governmentality that

can be seen in the research question, the aims of the ethnographic methodology to explore the culture and context of nurses' work, and the use of a combination of data collection methods that reinforce the complexity of explicit and tacit data that needed to be collected.

3.7.2 Triangulation

In this study, multiple distinct data sources were used (observation, interviews, field notes/memos, and documents), and I located evidence of similar codes and themes in different data sources. Overlapping codes in various sources of data enabled me to compare and contrast data, check inferences, corroborate interpretations (Hammersley & Atkinson, 2007, p. 102), and validating findings (Creswell & Poth, 2018; Roper & Shapira, 2000a).

3.7.3 Independent Peer Review of Data Analysis

Another validation strategy used in this study was an independent peer review of the steps taken in data analysis in order to provide an external check on the highly interpretive coding process (Lincoln & Guba, 1985). In much the same way as interrater reliability promotes rigour in quantitative research, my supervisor, committee members, and I read several interview transcripts and independently developed lists of preliminary descriptive codes. Next, we compared the main codes, and the intercoder agreement between general code names and the text segments assigned to each code was very high (Miles et al., 2014).

3.7.4 Reflexivity

Hammersley and Atkinson (2007) maintain that reflexivity is important to ensure the rigour of qualitative study findings because disclosing one's biases, values, and experiences enables the reader to understand the position from which the researcher undertakes the study. In turn, this helps the reader to identify how the researcher may have inadvertently shaped the interpretation or approach to the study. Clancy (2013) added that in order for the researcher to be

reflexive, they must implement processes to question their attitudes, thoughts, and reactions during the study as a first step in questioning how they shaped data collection and data analysis. Although I could not have identified all the ways I impacted the research process, I used memoing as a process to record my initial reactions, emotional connections, and resistance to collected data. Using memos, I was able to better understand how I was situated in relation to the data so that I could try to anticipate and monitor subsequent reactions and influences on the data. For instance, in some cases, knowing that I had an assumption or sensitivity to a topic area enabled me to change the wording of an interview question so that it may have been less leading (Grant et al., 2012). In addition, I used reflective questioning and reflexivity to continually check my immediate responses to the data, and reminders during the data collection phase to ensure that I asked participants to explain their clinical decision-making about their role as a nurse. As stated earlier, I added the word 'ask' to the top of my fieldwork notebook to ensure that I reminded myself to ask participants to explain their practice decisions. This was in recognition of the fact that I operated as half insider-half outsider in that I also worked as a nurse in the acute care setting.

3.7.5 Establishing a Rapport

Willgens et al. (2016) underscored the importance of establishing a rapport with participants in ethnographic work so that each member feels invited to share their experiences honestly. I engaged in periods of observation that required close contact with the participants and built a rapport with the participants, allowing me to gather sensitive data about the research question. Engaging with participants also enabled me to generate thick descriptions of the setting, context, and culture within which nurses worked by using direct quotations of interview transcripts.

3.7.6 Saturation

Saturation is used by many researchers as the key criterion in determining when qualitative data collection can end. While there is no general rule on how to calculate the most appropriate amount of time to spend on fieldwork (Roper & Shapira, 2000a, p. 13), some scholars advocate that when one reaches saturation, there will be repetition and replication in codes and themes, and no new information will be emerging from the data. This means that the appropriate sample size has been obtained and data collection can stop (Lincoln & Guba, 1985; Morse et al., 2002; Sandelowski, 1995). They go on to suggest that researchers should collect and analyze data until the point of saturation, as it enhances rigour by ensuring comprehension and completeness of data collection (Morse et al., 2002, p. 18). Proponents of this position advocate that data saturation is "the flagship of validity for qualitative research" that "meets the ontological and epistemological foundations of qualitative research" (Constantinou et al., 2017, p. 583).

On the other hand, scholars argue that in the pursuit of repetition and replication between data sets, saturation prioritizes notions of reliability and objectivity that are aligned with post-positivist quantitative paradigms (Boyatzis, 1998; Braun & Clarke, 2021). Thorne (2020) and Braun and Clarke (2021) also argue that it is not appropriate for qualitative researchers to declare they heard it all and understand it all (Hennick et al., 2017) about a topic and that further data collection would be redundant. Braun and Clarke (2013) also critique the use of saturation as a way to determine when qualitative data collection can end. They argue that qualitative studies using iterative, concurrent processes for data collection and analysis results in modifications to the interview guide, so it is not possible to attain saturation in these interview questions.

Although there are no well-accepted strategies to determine when to end qualitative data collection other than saturation as of yet, some recommendations are provided by these early

thinkers. There are also pragmatic reasons that lead to end data collection such as funding time limits, ethical board deadlines, or constraints on one's access to the study's settings (Braun & Clarke, 2021; Leese et al., 2021). In these cases, Braun and Clarke (2021) and Leese et al. (2021) encourage researchers to report on the richness and complexity of the data in addressing the research question rather than declaring that they reached saturation.

In this study, I stopped qualitative data collection for pragmatic reasons as the study units became closed to researchers and students during the COVID-19 pandemic. I am not claiming saturation in this study because I am not suggesting that these findings capture all of the possible realities for acute care nurses and administrators, and I do not assume that these themes are universally generalizable to others within this population. Instead, I am presenting some themes that might begin to describe the perspective of nurses and administrators working in hospital settings related to ACP practices. I also claim that, since there is much repetition and replication between the ethnographic data in this study, there might be some agreement between participants on the presented themes in relation to the research question. Finally, many of these themes are well supported in existing literature related to the impact of organizations on nurses' work, which further adds to their reliability (Lincoln & Guba, 1985).

3.8 Summary

In this chapter, I discussed the design of this study as it related to methodology, the philosophical paradigm, and methods. The next chapter (chapter 4) marks the beginning of the results section, and the focus will be on understanding the context in which nurses work on their units. In chapter 5, I will report findings on how organizational factors influenced the ACP work of nurses. Finally, chapter 6 will be the last results chapter, where I will broaden my viewpoint and explore the sociopolitical influences that have impacted nurses' ACP work.

Chapter Four: Understanding the Context of Acute Care Nursing Practice

This first findings chapter focuses on describing nurses' work in acute care practice as it relates to ACP. The chapter is organized around three main themes that contextualize the busyness of working with competing demands on nurses' time, scrambling to get things done, and caring for patients who "don't fit". Taken together, these factors create a situation in which ACP, is deprioritized within the context of care in acute care.

To begin, and grounded in my interview and field note data, I provide a composite portrayal of everyday nursing work in acute care settings, acknowledging that it is impossible to capture all of the nuance and complexities inherent in acute care nursing work. This portrayal it meant to provide a brief window into the realities of daily nursing work, and sets the stage for understanding the context in which nurses work in acute care settings. I begin with a vignette of a nurse named Judy (not her real name), who works on an acute care unit. Her experience represents a composite of the daily experiences of the nurses in my study. I then turn my attention to more fully describing the context of nursing work within acute care as participants respond to multiple competing demands, and care for complex patients that they perceive "don't fit" on acute care units. Next, I describe how this context impacts nurses in their efforts to integrate ACP into their work.

4.1 A Typical Day Shift for Judy

Judy is a middle-aged nurse who has worked in acute care for more than 10 years, caring for highly complex patients. At the beginning of her shift, she takes a moment to see which nurses she is working with so that she knows who to ask for help if she needs it, and who will be covering her assigned breaks. Judy typically cares for 5-6 patients on a given day, and begins her

shift by reviewing her patient assignment, figuring out when her break times are, and checking to see if she is caring for any patients that are located in non-traditional spaces like hallways or patient lounges. She also checks if there are any off-service patients, isolation patients, or alternative-level-of-care (ALC) patients (those awaiting long-term care placements) in the beds she is assigned to on her specialty unit. After gathering her information, Judy takes a quick moment to introduce herself to her patients, to "see the whites of their eyes" and ensure they are safe, breathing, and to ask if they need anything immediately (such as pain medication). Once morning medications are administered, and vital signs/glucometer readings are done, Judy charts this information before proceeding to help patients with their morning care. Typically, morning care includes assisting patients to the bathroom, transferring them to their lounge chair, setting them up with a washbasin, and for patients who require *total care*, helping to get them washed and dressed. During this time, Judy also answers call bells, while moving swiftly between rooms to ensure morning care is completed and to monitor the progress of her patients.

Each morning on her unit, there is an announcement for nurses to attend grand rounds in the team room. This is a meeting where members of the multidisciplinary team gather to discuss the care plans of all patients on the unit and how to expedite their discharge. Judy (like most of the other unit nurses) rarely attends, even though she spends the most time with her patients and knows them well. Judy explains that as a nurse, she feels that grand rounds are not a good use of her time since she has little influence patient discharge decisions, and this is not her role as a nurse. She continues to explain that these rounds are held in the morning, at the busiest time of the day for all nurses, and it is not possible to find time during her fast-paced morning to attend. Instead, Judy closely monitors the health status of her most complex patients, quickly moving from room to room. In addition to helping her patients with their morning care, she gets them

ready for breakfast, retrieves fresh linen and makes their beds, and administers prescribed medications, takes vital signs, changes dressings, and assists her patients with ambulation. On many shifts, Judy is not able to take a break in the morning as there is too much to be done, and doing so would mean falling behind in her work.

As the day progresses, Judy manages patient transfers and admissions or discharges, or she helps others with these tasks. She often assists her colleagues when needed with the admission of new patients, completing the patient history, assessing baseline vitals, processing physician orders, and gathering needed medications from the PIXIS machine. Discharges from the unit often occur as well, resulting in a lot of additional work for Judy, on top of her already heavy workload, because there is a new process for medication reconciliation requiring completion for discharged patients. Often, Judy and the other nurses make comments about how much longer discharges take using this *new* process, and how much it puts them behind in their daily plan of care, even though they understand that it is a process dictated by their recent accreditation report. When patients are transferred within or amongst her hospital's units, her workload changes significantly because she needs to adopt new patients into her care, and change her plan for completing tasks during the remainder of her shift. For Judy, it is very disruptive trying to manage an unpredictable patient load in the latter part of her shift. Often, unexpected things come up at the end of her shift too, and sometimes this results in the need for prompt intervention.

In addition to the work stated above, everyday occurrences in Judy's work consist of responding to physician inquiries, transferring patients to/from diagnostic imaging, participation in family conferences, redeployment to other units to aid in understaffing, and managing incidents such as an ileostomy leaks, epistaxis, acute chest pain, declining patients, deep vein

thromboses, missing meal trays, and unresponsive physicians. Judy speaks of the expectation of her organization that, during her shift, she complete monthly self-learning plans on topics such as medication reconciliation, electronic charting, safety training, and procedural changes. For the remainder of her shift, Judy's work is consumed by regular pain assessments, assessing and charting on telemetry strips, documentation, restocking or changing IV bags, emptying/recording fluid balance, and providing a shift report to the incoming shift.

4.2 Key Thematic Findings

Having outlined a typical dayshift of an acute care nurse, I now turn my focus to some of the key findings in this study. Acute care can be characterized as a setting that is fast-paced, complex, and an environment the focuses on meeting the needs of patients who have acute health issues. Nurses who worked in the participating acute care units described how they routinely care for patients who are acute ill while also providing care to those with complex, progressive life-limiting illness. Within the context of their work environments, many nurse participants revealed that ACP would be an important intervention for patients, but these nurses also admitted that few of them actually engage in ACP with their patients. Even though nurses working in these study settings provide care to patients with complex medical conditions, and progressive and advanced illnesses, the context of working in acute care is such that their treatment is focused on medical interventions and achieving mobility goals to facilitate discharge from hospital. This means that ACP is not "top of mind" for many nurses, even though their patients might benefit from it. In addition to working within a treatment-focused environment, nurses state that their capacity for having sensitive ACP conversations in the context of their fast-paced, intervention-focused work is highly challenging and problematic. Many nurse participants said they did not have the time, educational preparation, or physical space to initiate ACP because they have to scramble to

respond to other organizationally prioritized demands (e.g., medical tasks like medication administration and dressing changes or accreditation, and strategic planning initiatives such as medication reconciliation and self-learning plans), and still provide care to complex patients that they perceive "do not fit" on their unit. Consequently, many of the nurse participants expressed that they had limited capacity and supports to have sensitive conversations with patients even if they felt that the patient could benefit from ACP.

4.2.1 Working Within a Context of Multiple, Competing Demands

Nursing work in acute care is often characterized by participants as "putting out fires" as they respond to unpredictable workloads and need to constantly adjust to demands that are a part of their everyday work. The analogy of battling against fire is very common in the data. Interviews with nurses and insights from my observational fieldwork suggests that nurses are scrambling to manage the routine care of patients, while also responding to other competing demands. One nurse describes how overwhelmed she is in having such a heavy workload: "you just have to wing it sometimes."

While nurses pride themselves on being organized in the management of their daily workload, the acute care context is such that unexpected emergencies would regularly arise in their patient load that would throw them off course by pulling them in many different directions, requiring them to readjust. For instance, one nurse on the cardiology unit recalled a day when she was pulled in many directions: she set a patient up to soak a dressing in preparation for a dressing change when suddenly she was called away to manage epistaxis in another patient, and chest pain in yet another. Once she returned to the first patient, the nurse realized the wound needed to be soaked again because the water was now cold, yet she also knew that she needed to

administer routine medications to other patients soon and get her charting done to ensure physicians had adequate information to complete their morning rounds.

Still other nurses describe the busyness added to their workload when they have to respond to spontaneous competing demands in the organization that are outside of their regular workload. For instance, nurse participants speak of how common it is to be redeployed to other units to assist in understaffing. During one of my observations, two nurses who were working on the medical-palliative unit were reassigned to the emergency department by the unit manager in order to address a staffing shortage. This left the remaining nurses on the in-patient acute care unit short-staffed and struggling to adopt the additional patients into their workload. An interview with a unit administrator confirms that multiple competing demands and constant workload changes make the work of an acute care nurse challenging and stressful:

> Right now, I think nurses would be open to do things [like ACP] if they could work where they are supposed to be working. This is what I hear from my staff… "I'm booked today to work on cardiology, and I have five patients and so on, that's going to be my day. I might have five new patients, and I may have a patient to go for angio in the OR….and I will have 5 patients." It's not the case anymore, you might have 5, then end up with 4, then the nurse has to go and relieve in another unit because there's an admission in the hallway, pick up somebody in the hallway and then go downstairs to a CT scan with a patient because there is no one to go with them. They'd like to be staffed properly so they don't have to pick up, change units in the middle of a shift, work short, or any of those circumstances. That's what they want, so any tasks that are added on top of that craziness, and there is push back.

The constant re-prioritization of work to address routine and spontaneously arising demands means that many nurses have to miss their breaks in order to get their work done. As one nurse said:

> It's like we are jumping from fire to fire putting each one out until the end of our shift. We are just surviving each little crisis in the midst of overcapacity and understaffing.

Another nurse who worked on the oncology unit describes the unpredictability of her work and how the busyness of attending to multiple competing demands leaves little time for personalized care for patients:

> We just seem so rushed. It's more like spot care - kinda putting out fires rather than tending to their needs or the needs of the family. We are just so busy. Our environment is dynamic and unpredictable, it seems like we are just putting out fires and not really having the time to spend one on one with anybody. I do sit and talk to them, but not like I used to, like, those things don't worry me as much anymore, like it's more like did the task get done? And did it get done properly?

In addition to competing demands within nurses' workloads and spontaneous competing demands outside of their regular workloads, observational and interview data support the view that in their work of managing crises, nurses feel pressure to meet demands associated with organizational goals such as earlier discharges, completing online self-learning modules, and medication reconciliation. While many nurses understand the organizational focus on shorter lengths of stay and earlier discharges, nurses in this study struggle to meet those organizational goals. For instance, one cardiology nurse said: "we always have the pressure to hurry up, get them moving, get them out. I cannot work any faster to get these patients in and out," while another nurse in oncology added: "we cannot work any faster, we need more help, like we need more front-line workers to help with the patients that we do have and no one seems to be listening." The way that nurse participants describe their nursing work seems like they are in a crisis, in the trenches, battling against a powerful enemy, and working in awful conditions while people's lives hang in the balance.

Other nurse participants are frustrated by the organizational expectation to complete monthly self-learning plans that are not electronically accessible from home. Still other nurses refer to organizational goals set to meet accreditation requirements, such as medication reconciliation, and speak of the tremendous amount of work downloaded to them. Most nurses are overwhelmed with the organizational imposition of tasks on them that compete with the time that they have and need to care for patients. Managing multiple competing demands during their shift leaves nurses feeling frantic and unsettled. Because of this work context, one of the nurses said: "it takes a toll on me…I can't wait to get out of here." Another nurse participant indicates that the work is so overwhelming that she discourages younger people from going into nursing.

While the organizational setting imposes demands on nurses that increases their workload, organizations also add on processes and procedures for tasks that are expected of nurses. In the case of EOL discussions, one of the competing demands on nurses' time was that they were expected to engage in DNR conversations because it influences treatment options. There are organizational processes to routinely address DNR in the patient history form in each of the study sites but, at the time of this study, there were no such processes and procedures for ACP in any of the study sites. In completing organizationally expected tasks like DNR conversations, nurses are not expected to, or provided the time to address ACP. Some of the nurse participants state that expecting ACP to occur in acute care is not realistic or appropriate because the conversations are too unclear, uncomfortable, intimate, emotionally charged, lengthy, and the outcomes are not directly linked to clinical decision-making in their organization. One cardiology nurse stated that she only had time to focus on doing what absolutely needed to be done on her shift, which meant that ACP was not completed because it was not expected of her:

> It's less useful to health care providers to hear patients say that they are afraid of pain and want to live alone compared to if they say they would like to be ventilated and resuscitated. Do you see? That's clear to us. That's important because it is something that is directly applicable in their care here [on our unit]. I sometimes have the conversation with patients, but normally I do not have time. I am too busy running off my feet to be able to have five minutes to talk with patients about what gives their life meaning. The best I can do is talk with some of the patients about their code status. This is information that is important for me because it could have an impact on my shift, and it needs to be completed in the intake form. I need to know if I will be doing CPR on someone who is very sick.

This nurse explained that having DNR conversations is expected, straightforward, relevant, and more valuable to her in planning her patient's care than ACP conversations:

> I think in our setting, there is a comfort with goals of care treatment consent and less comfort with ACP. Maybe because we have to do DNRs? I want to say because to say yes or no to ventilation, yes or no to CPR, it is black and white, whereas if I ask about their values and beliefs at the EOL, I am not sure how this will benefit them or my care of them.

In the context of multiple competing demands, there is a tendency for nurses to focus only on what is expected of them by the organization. ACP is not an expected topic of conversation for nurses with their patients in that there is no process or procedure for these discussions in the plan of care. This is highlighted by one oncology nurse:

> It's not even a topic of conversation here. Nurses don't talk about it [ACP]. Nurses don't talk about it at breaks, nurses don't ask about it, and I have never heard them have this conversation when I have reviewed any patient charts.

4.2.2 Scrambling to Get Things Done

As an overall result of multiple competing demands on their time, nurse participants report that they are often scrambling to get things done. As one cardiology nurse states: "we don't have

time to talk to patients. I barely have time to look them in the eye once an hour and give them the pills that they are supposed to get on time before I run to the next one." During the interviews, nurse participants report that they focus on planning the next task, and they feel panicked, frazzled, and drowning in the number of tasks that they have left to do on their shift. Field note data supports this contention as I observed many nurses feeling pressured and overwhelmed, moving quickly from task to task, while expressing concern they will miss something or that they will be behind in their schedule. One nurse stated candidly: "Most of the time you basically run around like a chicken with its head cut off, and you are scrambling to make sure that you get everything done on time…with the call bells going off like crazy." Many nurses worry that their extreme busyness leads to a lower quality of care, and that patients often don't get what they need because of their heavy workload. This is well demonstrated in a quote from one nurse participant:

> I really think that we are overworked to the point that sometimes our patients are neglected, not purposefully, and we miss things. I really think we miss things, because I used to be able to walk into a room and say, oh, you are going to spike a temperature, or oh, you are not looking very good because I can tell by the colour of their skin, I don't have time for that now, so by the time I go in, 'Oh, you have a fever, how long have you had a fever?' 'Cause patients don't think they should be bothering us, because they see us running around like crazy.

This nurse goes on to express her frustration and distress at not being able to properly assess her acute care patients' needs due to her heavy workload. She also reveals her impression that patients are hesitant to engage with her for fear of adding to her workload. Another nurse shares her distress that the heaviness of her workload makes it a challenge to meet the basic needs of her patients. She states: "I didn't feel that we had the time to bathe them, turn and position them the way that they deserved." One of the nurse participants who worked on a

medical unit caring for heart failure patients describes her everyday work as jumping from one crisis to the other. The fast-paced care on a cardiology unit, and the complexity of patients, leads one nurse to say that she is only able to provide *spot care*, meaning that she had little time for in-depth assessments that she believes are necessary for quality care because they routinely operate at more than 100% capacity. As seen above, *putting out fires* is a common way that nurses describe their work in acute care. In these cases, it was used in reference to the provision of care on a unit where there are more patients to care for than beds available, and their nursing practice could only be to manage emergency and medical needs.

4.2.3 Caring for Complex Patients that Just "Don't Fit"

Within a context of the busyness of multiple competing demands, nurses describe how they have to scramble to get things done, but they also identify that their workload is made heavier by caring for patients who "don't fit" on their specialty unit. Participants state that having to care for these patients has a significant impact on their workload in that they need to manage patients with extreme anxiety, multifaceted social needs, financial insufficiency, substance use disorders, cognitive decline, inadequate housing, and frailty. These "off-service" patients are a source of frustration for some nurses who believe that admitting them to the specialty units is an inappropriate use of resources and services in the organization. One nurse with expertise in critical care expresses resentment at having to care for patients that *do not fit*, indicating that the type of patient she is caring for on the specialty units is not what she expected or trained for. She stated: "you get young people in with end stage cancer…the elderly who come in with urinal stuff…that's not what I signed up for."

Nurse participants who worked in specialty areas are particularly vocal about the inappropriateness of having to care for patients who are on a palliative trajectory or who are

waiting for placement into a community nursing home. One nurse explains: “it feels sometimes like we have nursing home assignments with a lot of ALCs, or we have many medical patients even though we are a cardiac unit.” The care of *off-service* or *misfit* patients on active medical, oncology, or cardiology specialty units is an important factor in ACP initiation because, as participants explain, the units are not adequately staffed for the additional workload associated with caring for medical or ALC patients with extensive daily living needs. With limited resources to assist with feeding, toileting, bathing, ambulation, and dressing, nurses have less time to initiate patient-centred care such as ACP. When asked if they engage the off-service or ALC patients in ACP, some nurses explain that they are not a good choice for ACP conversations because they are too complex, preoccupied with their current admission, frail, exhausted, and overwhelmed. For example, this nurse indicates that ACP cannot happen with this patient population because it requires too much time and energy to focus on the conversation:

> ACP questions require a lot of reflection, but they also require a certain level of patient understanding and patient energy. This type of mental activity is not at all appropriate for our patient load. Our patients have extreme pain, and have high levels of narcotics in their system to manage it, so they aren't able to reflect on these high level conversations and they do not have the energy to focus on it [ACP]. They are worried about their admission diagnosis. It is not the place to start asking questions about the future when they have to prioritize the energy that they have today, on dealing with today.

When one cardiology nurse participant reflects on his experience piloting ACP on the unit, he describes that most of his colleagues agree that ACP should not be a discussion that is initiated in acute care settings:

> A lot of nurses I think, felt like how I felt, was that this is not the time or the place to be discussing EOL care when somebody is acutely ill. This is something that needs to be discussed with the family doctors, just for the regular checkup.

Other nurse participants from this unit also describe feeling embarrassed and uncomfortable in having to ask patients about ACP in the midst of their health care crisis, fearing that the questions would cause patients additional anxiety. In some instances, they recall apologizing to patients for having to ask them about ACP.

4.3 The De-prioritization of ACP

When asked about ACP, some participants say that while they can see its overall benefits, it is almost impossible to imagine being able to do ACP given the multiple competing demands of their workload. Nurses express feeling overwhelmed in their daily work, and say that in this context, ACP is not a priority for them. This was confirmed by an administrator participant who admits that with the current workload in acute care, nurses do not have time to consider ACP as a core part of their practice. As the administrator says: “they are adding more beds, more responsibility and stuff, [ACP] can’t be done by the bedside nurse. It’s not the place. They don’t have room in their workload for that.” One nurse participant recalls being asked by her unit manager to engage her patient in ACP, and she states: “To be honest, with a full assignment, it was the least of my priorities.” Respondents feel they need to prioritize their time on competing demands that are critical to the management of the patient’s episodic acute illness, or on clinical issues that spontaneously arise during their shift. Another administrator comments that engaging in ACP “just wasn’t a priority for them. They [the nurses] are missing their breaks… they can’t go on break and eat. Sitting down and talking to a patient about [ACP] is the least of their worries.” Prioritizing life-sustaining medical tasks is the primary strategy used to manage the demands, as stated by one medical nurse: “I prioritize the critical tasks that need to be done to manage each little crisis and prevent bigger ones.” Another nurse working on the oncology unit agrees, stating: “We are taught to prioritize, and giving blood [for example], that takes priority.”

Task prioritization to meet urgent and immediate medical needs takes priority over having conversations with patients and families about planning for future health care decision-making. In this sense, ACP is not considered a priority for nurses working within the context of routine, spontaneous, and competing organizational demands. As one nurse participant describes it: “We can’t make [ACP] a priority for us. We are just trying to survive each shift in caring for unstable patients and properly administer life sustaining treatments using every moment in our day.”

4.4 Summary

In this chapter, I provided a descriptive account of nurse’s work in the context of acute care. My goal is to develop a deeper understanding of how the work context influences nurses’ capacity to engage in ACP with patients. Based on my interviews, observational fieldwork, and review of documents, acute care can be described as a practice setting with multiple competing demands, leaving nurses to scramble to get things done, caring for acutely ill patients while at the same time caring for patients with complex chronic illness that do not seem a good fit for the acute care environment. As a result of time constraints, multiple competing demands, and pressures to meet organizational imperatives such as timely discharge, paperwork, and working at overcapacity, many nurse participants and administrators admit that ACP conversations, while important, were not a priority in the everyday work of acute care nurses. Within this chapter, I also provide examples to highlight how nurses segregate their care of patients in order to manage crises with lack of time, and to prioritize tasks that align with organizational values and metrics. For instance, nurses speak of ACP as a distinct task to add on top of their existing workload, rather than considering it an embedded part of their patient-centred care. Without their awareness, they choose which tasks are a legitimate use of time and which ones are not, but they

also have clear ideas on which patients should be cared for on which units. In caring for patients in these ways, the nurses manage their workload within this complex and challenging context by planning and delivering care that aligns with the values of their organization, such as DNR assessments. From their perspective, ACP is simply not possible within their current acute care context.

Chapter Five:

Organizational and Operational Issues Imposing Order on Acute Care Nurses' ACP Work

Having described the impact of the everyday work of nurses and their ACP practices in chapter 4, I now turn my attention to the organizational and operational factors that impose order and structure on nurses' work, and affect their ability to engage in ACP. Organizational issues such as the financing of acute care, and the need to meet accreditation standards, have an impact on which institutional priorities are selected as a focus for nurses' work, and which ones are not. Institutional strategic plans are also used as a structure from which organizational decisions are made about how and where resources should be spent. Operational issues also impose order and structure on nurses' work. For instance, acute care organizations prioritize patient flow, consistently operating at overcapacity in terms of number and complexity of patients, and provide limited privacy for patients. These organizational and operational issues create contexts in which nurses feel it is almost impossible to engage their patients in ACP.

5.1 Historical Use of ACP in Study Settings

In order to contextualize the provision of nurses' ACP work in acute care, it is important to understand ACP efforts that take place in the study sites. The primary hospital in which this study is conducted tried to implement various forms of ACP in one of their units with minimal success. According to one manager, an ACP pilot project was trialed on her unit where registered nurses were educated and directed to engage patients aged 75 years or older in ACP. However, according to the manager, after several months of trying to initiate ACP with patients, the program was discontinued due to a lack of time, staff, and monetary resources. Although a lack of resources was a significant issue in the success of ACP implementation, data also showed that

many nurses and managers struggled with what ACP was and how it differed from DNR, as this manager suggested:

> Even though this unit was one of the ones that were supposed to do [ACP], I expect that not many nurses even know what [ACP] is really. I think most nurses would say that [ACP] means asking patients about their DNR status. I even need to remind myself that [ACP] is bigger than that and most of the time I can't remember how [ACP] is more than DNR actually. I find the words and meaning is not easy to remember.

In the secondary hospital, there was no hospital-wide palliative care consultation team, but there was a very active hospital-wide palliative care committee that met monthly to discuss issues associated with the care of patients with life-limiting illnesses. Despite several educational efforts made available to acute care nurses through their unit managers, and implementation of huddles focused on goals of care conversations with patients, most of these activities were physician-driven and not seen as part of the nursing role. In essence, even though the literature documents the benefits of ACP for patients living with life-limiting conditions, ACP was not a common practice on any of the study units in either hospital, nor was it seen as an organizational priority. Instead, organizational and operational issues created situations in which nurses felt it almost impossible to engage their patients in ACP.

5.2 Organizational Issues

Organizational issues structure and order the acute care setting and impact the ACP work of nurses. In the following section, I will discuss how nurses' practice is shaped by organizational governance and planning, the financing of acute care, accreditation standards, and strategic plans.

5.2.1 Organizational Governance and Planning

In this section, I describe the factors associated with organizational governance and planning, which impose order on the acute care system and impede nurses' ability to engage in ACP with patients. In particular, the financing of acute care creates a structure that leads to the prioritizing of patients requiring acute care treatment and procedures, and less so on the needs of deprioritized, elderly patients with EOL care needs such as ACP. The expectation of nurses to fully engage in and support accreditation standards is another barrier to initiating ACP with acute care patients, because the prioritization of these necessary but time consuming initiatives are in direct competition for nurses' time and focus during their shift. Consequently, relational aspects of patient-centred care like ACP were not completed. Finally, organizational strategic plans in these settings prescribe which topics will be funded for educational training. Specifically, organizational planning prioritizes their resources on safety and regulatory training rather than on the development of relational skills like ACP.

5.2.2 The Financing of Acute Care

This section will provide a brief overview of the funding model for acute care hospitals in Ontario in order to identify the metrics used to determine organizational priorities in acute care settings. Based on the Excellent Care for All Act (Government of Ontario, 2010), the Ontario Ministry of Health and Long-Term Care (MOHLTC) developed the *Excellent Care for All Strategy* and the *Health System Funding Strategy* aimed at quality, responsibility, capacity, and availability. Aligned with these strategies, 30% of hospital funding was called Global Funding, which paid for the operating costs of the facility, while the remaining 70% of funding was called Patient-Based Funding (PBF) (Sutherland, 2011). From there, PBF was further separated into Health-Based Allocation Model funding and Quality-Based Procedures funding, and outcomes

from these indicators were benchmarked against peer hospitals to identify efficiencies. Metrics associated with the amount of PBF provided to organizations was based on variables such as regional demographics, expected complexity of care, and the number of patients admitted and efficiently treated for specific acute and chronic elective and non-elective procedures (Government of Ontario, 2021).

MOHLTC funding structures and measurement outcomes impose order on the acute care system. Specifically, this leads to the prioritization of acute care procedures/treatments and tasks that promote the efficient flow of acute care patients throughout the system. One administrator speaks of the organizational complexity involved in meeting patient flow metrics and the implications of not achieving provincial standards:

> Lots of pressures, right? If we have too many ALC patients, we can't get all the post-ops in or we have to cancel post-ops or we create a backlog in emerg, but we ultimately lose funding. There is real money attached to that. We are always competing with each other for funding and benchmarks internally too. Emerg want people out, surgical floors don't want medical patients, they want surgical patients so that they can meet their quotas for so many hips and knees…so it is just a huge push and pull trying to co-ordinate all the multiple pressures.

As seen in this passage, the metrics required to secure funding in acute care systems imposes a type of order and structure on the whole acute care system by setting priorities for the workflow of nurses. Administrator participants went on to describe that within acute care settings, creative organizational procedures are also implemented to circumvent the expected time interval from admission to discharge if there are delays in transferring patients to community settings such as long-term care. For instance, this occurs with ALC patients. One participant states that patients become ALC when they occupy an acute care hospital bed, and do not require intense resources or services. Once these patients are defined as ALC by their

attending physician, the expected time interval for discharge is no longer applicable. Another participant wonders if there are so many ALC patients occupying acute care beds because designating them as ALC removes the funding-related pressure to discharge them within the expected time interval: “at the end of it all, if we don’t get people out, they end up becoming ALC patients and that further complicates the problem.” As seen in these examples, funding structures work to prioritize acute care treatments, procedures, and tasks to promote patient flow out of the hospital setting. These govern, organize, and control the work of nurses in acute care settings, making it extremely difficult to engage in tasks associated with the care of deprioritized older, EOL, and ALC patients, such as ACP.

5.2.3 Meeting Accreditation Standards

In addition to the order and structure that financing metrics apply to acute care operations, organizational accreditation imposes additional demands on nurses that compete for the time allotted to care for patients. Organizational documents show that accreditation is a quadrennial process aimed at increasing care quality. During this process, Accreditation Canada provides an independent, third-party assessment of health care organizations based on 100 standards of excellence for acute care centres in Canada. Some participants refer to examples of accreditation standards and relay practices that are a priority in their organization and how they affect the workload of nurses. Examples of practices that become a priority in these settings because of the accreditation process are medication reconciliation, electronic medical records, falls prevention, standardized information transfer at shift change, and removing abbreviations in charts. These biomedical and legal standards of excellence become the focus in the study sites, with associated resources assigned to them as organizations approach their accreditation assessment year. In turn, the organizational accreditation standards become priorities that are funneled down to nurses to

actualize in their work. However, relational domains like ACP are not prioritized in this way. The organizational focus on addressing accreditation standards is stated by one nurse who says that her manager reminds staff to: "*Please make sure you do this SLP [self-learning plan] for 20 minutes*. But, that could have been that 20 minutes that I could have been having the ACP conversation." The acute care organization is directing nurses to focus more time on accreditation requirements during their shift, further limiting the amount of time they can engage in direct patient care. Nurses agree that having to change their practice to address accreditation standards is overwhelming: "Like the medication cart for example, it had to happen because of accreditation in med safety…and you have to find a way to make it happen." Another cardiology nurse describes how these organizational processes like accreditation get in the way of her being able to do her job with patients:

> Discharges also now have so many steps and it is so much more complex than it used to be. All of that extra work is downloaded to the nurses. That's another example of how the decisions of upper management have increased our non-patient workload. I think discharge was an issue with the last accreditation so we now have more complex processes but the impact is significant on our workload and limits the time we have with patients.

Unit administrators who participated in this study are very aware of how accreditation processes overwhelm nurses on their units. One administrator, for example, talks about the additional workload for oncology nurses on her unit:

> We cannot expect front line nurses to have a 6 and 7 patient assignment and it's just like, you know, in and out, pushing discharges, getting new admissions…they're overwhelmed right now with the amount of work that we are doing especially with accreditation. With accreditation, we are doing med rec, information transfer, starting bedside reporting with our counterparts nights and days. It's a lot of change in a short amount of time that's coming down the pipe, there is so much education that is being kinda thrown at them right now, that they're just full. There has to be a point when we stop asking them to do more.

> So, without the resources I don't think we can take anything else on. Like, we are barely managing as it is.

These data support that accreditation-based institutional priorities compete for time during nurses' shifts, leaving less time for EOL conversations with patients.

5.2.4 Strategic Plans as a Driver in Resource Decision-making

Institutional strategic plans play a key role in setting the direction for many health organizations, and this is the case for the hospitals that are the setting for this study. According to documents that are collected and used as supplementary data in these analyses, the strategic plans from study sites are primarily based on meeting financial metrics, accreditation standards, Ontario's Health Quality Indicators, and Ontario's Excellent Care for All Act (Government of Ontario, 2010). Interviews with key informants describe how strategic plans are a driver for organizational initiatives, directions, and resource allocation. One administrator summarizes that institutional strategic plans drive the work plans and key milestones to be achieved:

> We have a work plan that has laid out some key milestones that we can deliver in each year of the 6-year strategic plan and then on an annual basis, we work that into sort of more detailed plans of what we are going to do for the given calendar year and set aside funding within our operating budget to help support the implementation of those plans. So, as part of that process on an annual basis with our senior team, we look at the plan for the year and what resources we can allocate from that pool of funding that we have set aside, to help support the plan...it sorta goes from strategic plan to implementation plan. That implementation plan would cascade down to program plans within the organization including setting performance goals through the chief of staff and the CEO, annual performance goals set by the board and the other VP's on the senior leadership team, directors, managers, and performance goals linked back to that strategy and the overall plan linked back to that strategy.

According to this administrator, institutional strategic plans set the stage for the organizational priorities that are the focus in a given year. On all units, ACP initiatives are seen as "add-ons," and are not prioritized or funded by the organization. At one site, there was a pilot program many years ago that prioritized ACP on their unit. However, since ACP was not positioned within the organizational strategic plan at the time, adequate funding and resources were not allotted to create and sustain an ACP program on this unit or implemented on other units, and the initiative ended in this organization. One administrator commented on her impression of where ACP fits in the organizational priorities of the acute care setting, stating: "Whether or not [ACP] rolls out on our units is going to be dependent on its priority in the organization's strategic plan. Our strategic plan right now is fiscal… and I don't see ACP in there." Other key informants agree that ACP is not overtly evident in the strategic plan, but that it might be loosely associated with patient-centred care, patient decision-making, and client satisfaction in the organizational priorities. Given that participants do not overtly identify ACP in the strategic plan, they feel that there is no organizational expectation to have nurses make time to prioritize these conversations in their overwhelmingly heavy workload. As one manager states: "when it becomes really important to the viability of this organization, resources will get allocated and we will be told to make time for [ACP]. But until then, [ACP] will not be done. The system is not operationalized towards ACP." One nurse recommends adding ACP to the history assessment tool in their cardiology unit: "The first step would be to putting [ACP] on the history form and have it as a standing item on the care plan during admission, just like discharge planning."

5.2.4.1 Educational preparation.

Without overt organizational pressure to engage patients in ACP, and with ACP not being part of institutional strategic priorities, most of the nurses who participated in this study state that they do not initiate ACP in their practice. Although many nurses value the importance of ACP, they reiterate that they have too many other priorities that compete for time in their day. They also state that their organization has never assigned resources to educate them on engaging patients in ACP, even at the primary site when there was a pilot ACP program implemented. In this pilot program, there were only unit champions that nurses could access if they had questions about the new ACP process that they needed to implement. Nurse participants name a variety of other organizationally supported education programs with compulsory self-learning plans, such as non-violent crisis intervention, central lines, blood gas reading, and WHIMIS, but they feel that a lack of education on the topic of ACP is one of the biggest barriers to understanding "what ACP is and how to do it while managing our workload," as one nurse says. In the words of one oncology nurse who firmly believes that a lack of organization-based education was the primary reason for nurses' lack of comfort with ACP, "you know [nurses] haven't been taught about ACP and there is no kind of course on that here, nobody in my unit knows anything about it… I don't understand why there is nothing for that." A cardiology nurse agrees, stating that education on ACP is a critical first step to promoting the conversation with patients on her unit:

> I think the biggest barrier to ACP on our unit has been education. It's just making it known and making nurses aware of ACP policies. I feel that staff just don't think about it. So if they know about it and we kinda get the education out there that this is what we are going to do, get the policies in place, I feel that it would be like a quick shoe in, let's make it happen.

The general sense from these data is that participants think one of the main barriers to engaging in ACP and promoting nurses' comfort in having the conversation is lack of education. They feel that as there is no overt reference to ACP in the strategic plan, there are no educational

resources assigned to it to assist in its implementation, and that organizational decisions and resource allocation is structured towards organizational priorities associated with accreditation standards, institutional strategic plans, or safety. Notably, while significant educational opportunities are available related to organizationally prioritized tasks, legalities, and regulatory skills in acute care settings, there are few, if any resources for nurses to develop and practice relational skills (i.e., ACP) that are relevant to the care of their patients.

5.3 Operational Issues

In addition to organizational governance and plans, operational issues also organize the acute care setting and impact nurses' ACP work. Acute care settings are shaped by provincial funding and related metrics, so operational issues such as prioritizing patient flow, overcapacity, and limited privacy impose order and structure on nurses' work. In the following section, I will discuss how nurses are expected to reorganize their work to complete tasks that support the flow and discharge of patients. I will also illustrate how operating at overcapacity has a direct impact on nurses' work, and how it limits the amount of time that they have with patients, and the physical space and privacy that patients have to engage in sensitive conversations like ACP.

5.3.1 Maximizing Patient Flow

A major organizational issue that has had an influence on the work of nurses is the need to maximize patient flow to expedite discharges. Other studies in acute care settings have also highlighted how nurses' work is influenced by the drive to discharge patients out of hospital (Nicosia et al., 2018). One administrator in this study explains that patient flow determines operational priorities on her medical unit:

> There is a particular length of stay for all procedures. If the expected length of stay is 3 days and that patient stays in for 5, well it's a bigger cost than the dollars that we were going to get for that procedure and there is a push to get them out earlier.

Many nurse participants are at odds with the tension between the fast turnover of patients to maximize patient flow and patient-centred care. In particular, nurses resent the persistent pressures to "hurry up, get [the patient] moving, get them out, so we can get the next patient in." One nurse working on a medical unit describes the pressure she feels to speed up patient discharges in her practice:

> We had this lady…come up from bed allocation, and they ask us, *ok, Who is ready for discharge tomorrow? What are their barriers for discharge? What are they missing?* They are trying to record all of this, so they can try and figure out why are patients staying longer than they have to, and what are the barriers to discharge. We [nurses] do everything that we are supposed to do, we know we are supposed to get them out of the hospital!

Another cardiology nurse relays her frustration with the fast turnover of patients and how maximizing patient flow does not allow for proper discharge planning or time for conversations such as ACP. According to this nurse, "we barely have time to talk about discharge planning, let alone anything else! Ok, and you're in here and we are planning to kick you out." Many nurse participants speak of their stress, discomfort, and frustration with the organizational push to discharge patients faster because it is not patient-centred. In certain cases, patients were not ready for discharge, community services were not prepared to properly care for the patients at home, or they did not have time to engage in patient-centred care conversations like ACP.

Maximizing patient flow also means that many acute care patients had shortened lengths of stay, which decreases the amount of clinical time nurses had to care for patients. Some nurses lamented how acute care nursing practice has changed over the years, reflecting that shortened lengths of stay contributes to fewer opportunities for nurses to engage patients in meaningful

relational discussions (like ACP). One cardiology nurse reflects on how his task-oriented approach to moving patients through the system organizes his time with patients:

> We do our best obviously to try to talk to our patients but just to sit down and have a conversation, it doesn't happen very often and if it does, it's pretty quick and to the point focusing on what we need to know 'cause you have like a million other things to do and you know that these people have to go home so you can get the patients that are waiting for the bed.

Another cardiology nurse agrees, stating that with an organizational focus on patient flow in the acute care system, there is little time that she has with the patient and she could not fit ACP into her everyday work:

> When you have this much movement [flow] on an acute care floor, you go to see [the patient] and they are gone for an x-ray, they are gone for angio, they are gone for echo. I can plan to do ACP on my shift, but with their shortened stay, it doesn't get done.

In their interviews, many nurses reflect on how the organizational prioritization of patient flow results in operational issues that are barriers to ACP conversations. The steady pressure to turn patients over in the system imposes order and structure on nurses' work in three ways: 1) nurses are expected to spend their time only on tasks that promote early discharge, 2) nurses are often pulled away from the bedside by administrators to brainstorm on how to discharge their patients faster, and 3) patients' length of stay are shorter resulting in less time for nurses to engage in relational care. Taken together, nurses describe that they have little opportunity to initiate ACP with their acute care patients.

5.3.2 Operating at Overcapacity

Overcapacity of patients is another operational issue that shapes the work of nurses and their ability to engage in ACP. Overcapacity of patients on acute care units is a common theme

discussed in the interviews and observed on the acute care units. One oncology nurse said that they often have more patients than beds on their unit:

> We are consistently at 110% overcapacity…all they [administration] want to do is off load emerg. The hospital…puts 1 [emerg] patient, 2 [emerg] patients, and 3 [emerg] patients in the hallway and cancels scheduled surgeries…to make sure that emerg is kinda offloaded.

This is not unusual according to the literature. The Ontario Health Coalition (2016) states that, although it is considered overcapacity to have more than 85% of acute care beds occupied, it is common to have capacity rates higher than 95%. As explained by administrators in this study, the reason for overcapacity in their organizations is that, for statistical purposes, patients need to be moved out of the emergency department so that organizations receive funding for placing them on a unit within the benchmarked timeframe. Field notes support that acute care patients are often cared for in non-traditional spaces on the units like hallways, meeting rooms, or lounges. In the interviews, many respondents speak about how overcapacity influences their work as a nurse. For instance, one nurse who worked on the medical unit describes the increased workload in adding hallway patients to her already-full workload assignment: "hallway patients impact us the most…we have 2 over census, 4 lounge, and up to 4 hallway spots, so that's 8 up to 10 extra patients that are unfunded and unplanned." Most participants express feelings of exhaustion and distress in caring for patients in the hallway because additional patients means "…everything is longer, everything is harder… everything is just more work." However, it also means that physiological tasks that promote discharge need to be prioritized, thereby bypassing patient-centred care relational tasks like ACP.

One nurse from the cardiology unit summarizes his perspective of caring for hallway patients in an overcapacity scenario: "We are just surviving each little crisis in the midst of overcapacity and understaffing." In this statement, he uses the term *surviving*. The concept of

aiming to *survive* one's shift is common amongst many respondents. Many of them state that when confronted with the monumental amount of tasks that they are expected to complete with their patients in a shift, they begin to operate in a crisis mode to prioritize the tasks that support organizational goals (like patient flow and discharge) and patient safety. Unfortunately, relational tasks such as ACP are not captured in the organizational goals, not considered a priority for patient safety, and therefore not completed.

5.3.3 Lack of Privacy

In addition to the added workload of operating over census, respondents state that one of the main concerns related to the care of patients in non-traditional rooms (hallways, lounges, or closets) is the loss of patient privacy. Patients cared for in hallways, lounges, or closets often only have a curtain or two separating the physical space for their bed from the public passing in the hallway beside them. The physical set up of hallway beds imposes limits on the types of conversations that nurses feel they can have with their patients. Nurses state that private and sensitive conversations such as ACP are very challenging in such a public setting because it offers no confidentiality. This is the perspective of a nurse working on the oncology unit:

> When I am in a room with a patient, I am more comfortable…I can talk a little more freely as I have more privacy. I find in the hallway I don't get personal with them, I just do my duties that I have to do with them.

Other nurses agree, and feel that the lack of privacy with hallway patients limits the questions they ask about the patient's history, resuscitation status, relationship status, elimination patterns, and ACP. One of the oncology nurses states that she had:

> A hard time doing the history with them because there's a lot of personal questions in that history. You know, I don't feel that I can get into details about DNRs, I don't ask…I kinda bleep over it…because there are always people walking in the hallway.

> I know it's terrible to do, but I feel that there is not enough privacy in the hallways and that bothers me to no end.

Another nurse working in cardiology agrees that she was not able to initiate ACP in a context of overcapacity even though she values ACP in her patient-centred care:

> I believe that nurses would agree that it is important to have this conversation with the patients and their families or their next of kin SDM. But I also feel that they don't have time to actually have the conversation properly in a private space because of our overcapacity. We have patients in hallways, it is really difficult to have that conversation in the hallway when everybody is walking by…or in lounge areas where there are three other patients listening to your conversation through the curtains.

In short, the operational issue of overcapacity gives rise to a loss of privacy for patients and limited physical space to engage patients in sensitive conversations such as ACP. Many participants cited this as a barrier to successfully engage acute care patients in ACP.

5.4 Summary

In summary, organizational and operational issues impose order and structure on nurses' work in acute care settings, and have an impact on their ability to engage patients in ACP. Organizational issues shaping nurses' work are the financing of acute care, meeting accreditation standards, and strategic plans. Operationally, issues that shape nurses' engagement in ACP with their patients include the prioritization of patient flow, operating at overcapacity, and a loss of privacy for patients. Consequently, the organizational and operational context of these acute care organizations do not support the work of ACP for nurses.

Chapter Six: Understanding the Context of Acute Health Care Settings

In chapter 4, I described nurses' work and routine ACP practices. In that chapter, nurses acknowledged that they did not have the time or capacity to do ACP because they were scrambling to complete multiple tasks that competed for their time while managing complex and critically ill patients. In their work, nurses described how they segregated their care to manage their time by choosing to engage in organizationally legitimized tasks. In chapter 5, I highlighted the organizational and operational issues that shaped nurses' work in acute care settings, such as the financing of acute care, accreditation and strategic planning priorities, patient flow, overcapacity, and a loss of privacy for patients. In this chapter, I focus on the larger contexts in which acute care nurses are working more broadly to show how nursing workforce issues and a lack of involvement in unit and organizational decision-making can influence how nursing work unfolds, and can diminish nurses' capacity to engage in ACP. In addition, while ACP was seen as an important imperative organizationally, an aging population combined with a lack of community-based supports and long-term care beds created the conditions in which nurses were only able to do the bare minimum. Finally, I will show how the *fix-it* culture of acute care organizations positions nurses in tenuous situations where they realize what should be done for their patients, but feel the death defying culture within acute care does not always support them practicing in ways that are consistent with what they believe patients need. These factors profoundly influence nurses' capacity to engage in ACP with their patients. By illuminating the contexts that shape nurses' work in acute care settings, it becomes clear that ACP may not be an entirely realistic practice to occur in this setting.

6.1 Nursing Workforce Issues

Nurses in Canada are leaving the profession at a higher rate than we are able to replace (McGillis Hall & Visekruna, 2020). According to the Registered Nurses' Association of Ontario (2021), we are in the midst of a nursing shortage that will only get worse in the next decade. One recent study found, for instance, that 59.7% of sampled nurses are planning to leave the profession within the next 12 months (McGillis Hall & Visekruna, 2020). Many participants in this study also spoke of leaving the workforce, particularly through early retirement or leaving the profession altogether. Heavy workloads, long shifts with minimal breaks, and being placed in clinical situations that make nurses feel they are practicing in an unsafe manner are cited as some of the main reasons that nurses are planning to leave the profession (Maunder et al., 2021; McGillis Hall & Visekruna, 2020; Shah et al., 2021). Retaining nurses in acute care is thought to be particularly challenging (Van Osch et al., 2018).

The global crisis to maintain experienced nurses is also seen in the data from this study. During my observations and interviews with nurse participants, many senior nurses comment on the challenges of working with new graduates who they do not feel were completely prepared for what was expected of them. In some cases, junior nursing staff, having only been a nurse for 2 years, are considered senior in their positions. For some nurses in this study, working with only young, inexperienced nurses leaves them feeling nervous that patient care is at risk and that there are not enough senior nurses to manage emergencies on their unit. Other nurse participants are concerned that junior nurses do not have the kind of mentoring needed to develop critical skills like multi-tasking, or prioritization of patient care, and they have not developed confidence in more complex relational care that is required with their medically fragile patient population. Some participants say that nurses with less experience tend to focus more on the tasks associated

with the role, and those the organization expects of them. While many senior nurses understood their junior colleagues' need to build necessary skills, some lamented that new nurses were "uncomfortable asking that [ACP] question. Seeing the unit blend with the number of inexperienced staff that we have sometimes, I can see how the question is not routinely initiated on our unit." The relative lack of experienced nurses, and the perception that ACP is an advanced communication process, means that ACP is something that is infrequently done on these units.

6.2 Nursing's Lack of Involvement in Unit and Organizational Decision-making

Canada's heath care system is hierarchically structured and oriented to prioritize biomedical care and efficiency (Harvey et al., 2020; Nicosia et al., 2018; Rankin & Campbell, 2009). Within the business-like model of acute care, nurse participants in this study describe that they feel uninvolved (or sometimes even unrecognized) in organizational decision-making related to unit initiatives, even though they spend the most time doing the business of health care. Many of the nurses who participated in this study state that they are frustrated with the lack of opportunities that they have to be involved in the prioritization of organizational initiatives on their unit, or to have input into how to best implement strategic directions:

> It's just a matter of this needs to be done and you guys are the ones that are going to be doing it. They never asked us if it should be done, or how it might be best adopted. Management just decided it would now be an expectation on our workload.

One oncology nurse describes her view of how initiatives are introduced and managed on her unit:

> It is just thrown on us with little empathy or even acknowledgment of how this was affecting the management of our existing work with patients. But it seems like this is the way the hospital leads and the way they do stuff. It's just, this is the expectation that new tasks are done and there are no excuses why it can't get done.

This kind of top down decision-making is perceived by many of the nurse participants to be a common practice that leaves them feeling that their concerns and contributions are undervalued. For instance, prior to this study, an ACP initiative had been implemented in one of the study sites. However, nurse participants reflected that they did not have a choice if they would be piloting the ACP program as it was a managerial "directive, or announcement at a team huddle that this is happening, here are the forms, here is a summary of what kinds of questions to discuss with your patient, and now go and do it." Both nurse and administrative participants relayed that, ultimately, the ACP initiative, while seen as an organizational priority but not included in the strategic plan, was unsuccessful. Nurses were left feeling that they had not been consulted, nor had any additional resources or education been put in place that would allow for success. The result was little buy-in of the ACP initiative by nurses on the acute care units.

When asked how management could better support their work as nurses on the unit, one cardiology nurse responds: "they need to ask us how best to implement these outrageous ideas on our unit because we are the ones doing the work." Another nurse on the oncology unit agrees, commenting:

> I just kinda wish that organizational initiatives would include consultation with more front line nurses because we have insight on what will work in our work setting, what might need to be modified, and how it should be evaluated. Only we have that insight.

The lack of influence on, or input into, decisions that affect their work leaves many nurses in this study feeling disengaged from their organizations. During my observations, I noticed that many new protocols and organizational initiatives were posted on bulletin boards, but many nurses did not take notice of these and, when asked, many nurses were not aware of why these organizational initiatives were prioritized by their administration. For instance, when I asked why their organization was implementing new initiatives such as skin care protocols, complex

discharge planning processes, goals of care conversations, or strategic planning initiatives, nurses stated: “I’m not sure who makes these decisions,” “why our hospital? I don’t know,” and “I don’t know what it is, why this is on the bulletin board, or where these initiatives came from.” One nurse on the cardiology unit stated: “Truthfully, I don’t know why we focus on certain things here. I don’t think it is communicated very effectively to us.”

Most of the nurse participants understand that organizational changes and revisions to policies and procedures are common in the fast-paced environment in which they work. Some nurses, however, wonder about the motivations behind changes, and question whether organizational policy changes are related to improving patient care. One nurse states: “I don’t know if [the organizational focus] was a political thing, accreditation, or a money thing.” Lack of staffing is frequently brought up as an issue that nurses feel they have little say in or influence over. Along with the nursing shortage, mentioned above, many of the nurse participants feel their advocacy efforts for more nursing staff go unheard as the organization hires middle management staff to problem solve organizational inefficiencies. Participants perceive this response to their repeated requests as dismissive, and their lack of input in addressing clinical issues impacting patient care is discouraging. As one nurse states: “we cannot work any faster, we need more help, like we need more front line workers to help with the patients that we do have and no one seems to be listening. Instead, we are hiring more middle management.”

In addition, nurse respondents state that the managerial presence on the unit is inadequate, which makes them feel like the clinical issues facing nurses at the bedside are not being heard, understood, or valued by administrators. In the words of one nurse working on the medical unit, “management staff do not understand the work of nurses. Maybe it would be helpful to have them shadowing us a few days/month to see what impacts our practice and our patients.” This

nurse feels that having managers more closely connected to them might be one way of increasing their voice in the organization in order to have clinical issues brought to the decision-making table. Even during the course of my fieldwork, some nurses asked desperately if there was any way that I could be an agent to inform management of the factors that are impacting nurses' work and patient experiences on the front line. Their lack of positional power, agency, and voice in organizational decisions leaves nurses in this study feeling disengaged with management, uncommitted to organizational initiatives, and discouraged that initiatives that they found valuable to patient care (i.e., ACP) were not part of the direction of the organization.

6.3 Working in the "Fix-it" Culture of Acute Care

Research suggests that ACP is one intervention that can potentially prevent unnecessary medical interventions in acute care (Detering et al., 2010; McMahan et al., 2020). Canadian studies show that many patients, particularly those with progressive life-limiting illness, would choose other options to acute intervention if they knew they existed (Wong et al., 2016). Time and time again, over the course of this study, nurses and administrators talk about the increasing number of patients in acute care who are designated as ALC, and are in an acute care bed because community-based options are limited. Often, though, nurses report that patients receive interventions that may be unwarranted or of little benefit. It is through these experiences that some nurses come to see ACP as a way to provide patients with a voice in their own health care. At the same time, some nurses comment that they feel that the acute care setting is "death defying" and "aimed to save people." According to some nurses, this "fix it" attitude permeates the care in acute care, with one nurse stating: "We put a veil over death."

As previously reported, nurses in this study often felt unprepared for ACP conversations, and some felt it was not their responsibility to have these conversations with patients.

Concurrently, these nurses report that their physician colleagues also seem to have discomfort in talking to patients about EOL issues. One cardiology nurse implies that his cardiologist colleagues had trouble having sensitive conversations:

> Physicians don't want to have conversations about death and dying...a lot of these physicians want to talk about positive outcomes, treatments…we are not going to talk about death and dying and we are not going to talk about those things.

Another nurse working on an acute care medical unit agrees that talking about the possibility of EOL seems uncomfortable for physicians because she believes they are focused on trying to fix patients instead of planning EOL with patients and their family members:

> For physicians to… start talking about dying, it almost feels like we are starting to set them up for failure. No one wants to put their finger on it and talk about it [dying]. It's so uncomfortable for everyone…Talking to physicians when we know that death is happening and this is going to happen very soon, it's like trying to rip out a nail with your bare hand.

This nurse goes on to explain the challenges that she faces in getting physicians to talk with patients and families about EOL care, or even to consider DNR orders. She questioned why there seems to be such discomfort among her physician colleagues and why futile procedures continue:

> Trying to get them to order that DNR or get them to speak to family… Even when they are literally pre-coding and the doctor still refuses to talk to family about DNR. I am not sure if they feel like it is a medical failure? Is it because they have monetary value in keeping that patient alive longer? And then they order more tests that are expensive…these doctors are doing futile procedures and no one knows what the patient wants.

The frustrations that some nurses feel, and the perception that ACP is not within their scope of practice, makes some nurses conclude that ACP should be initiated "long before the patient gets to the hospital" in places other than acute care. While nurses recognize the importance of ACP, they also feel that the "fix it" culture of acute care puts these patients at risk

for futile treatments if ACP is not done prior to hospitalization. As one nurse said, “ACP is not something that starts in the hospital” and recommends that:

> If we are serious about ACP… it needs to start in the community…it’s very, very important to get done at some stage and follow it. But not at the bedside in acute care. It’s gotta be really pushed at the community level, senior’s homes, nursing homes, retirement residences, doctor’s offices, on the news, billboards, you name it. It needs to be out there and people need to be aware because they want their voice heard.

6.4 Summary

In this chapter, the sociopolitical, cultural, and political traditions that contextualize acute care settings had an impact on nurses’ ability to engage patients in ACP. In particular, nursing workforce issues and a lack of involvement in unit and organizational decision-making influenced how nursing work unfolded and diminished nurses’ capacity to engage in ACP. Aging populations and a lack of community-based supports and long-term care beds added complexity to nurses’ work, resulting in their ability to do only the bare minimum for patients. I also found that the pervasive “fix-it” culture of acute care organizations did not allow nurses to prioritize EOL conversations, even if they felt it was what patients needed. These factors profoundly influenced nurses’ capacity to engage in ACP with their patients.

Chapter Seven:

Discussion and Conclusions - Locating the Findings in a Broader Social Context

To date, there is little research exploring how the social and organizational structures and processes of acute care settings influence nurses' uptake of ACP in their practice. The research question guiding this study was: *How is nursing practice shaped and influenced by the organizational context of acute care to enable or constrain nurses' efforts in ACP?* The overall goal was to understand how unit, organizational, and social contexts shape the ability of nurses to engage in ACP as part of their everyday practice with acute care patients. The purpose of this study is well aligned with ethnography in that I wanted to explore the organizational context as a social phenomenon, and the decision-making process of its people within their context of everyday work (Denzin & Lincoln, 2011). Ethnography also allowed me to employ multiple data collection methods to observe the behaviour of nurses on the units, and understand the tacit complexities of nurses' decision-making influencing their ACP practice. I used various methods to gather data within a broader social context to better understand the emic point of view of nurses (Spradley, 1979; Spradley, 1980). Through the use of ethnography, I was able to employ my insider knowledge of acute care nursing to focus the data collection on the situations, interactions, units, and moments in the nurses' day in which ACP may occur. I used Foucault's lens through which governance and structures bend "subjects to a single uniform mass" (Foucault, 1975, p. 170) "in order to obtain an efficient machine" (Foucault, 1975, p. 164). This prompts the following question that I asked of the data: *What are the forms of order, structure, and influence impacting nurses' work and impacting their capacity to engage in ACP?* Also, Foucault's interest in the governmental analysis of institutions and policy to illuminate the wider

contextual, institutional, and social factors impacting the behaviour of workers motivated me to ask: *What are the systems and structures at play? Who do they serve and what are their effects? What is the effect of the language that is being used? What are the organizational values-of-the-day that are organizing this setting and what is their effect on workers? Who is being served by the organizational values-of-the-day? What is the effect of the language nurses are using and how they are describing their work?* Finally, Foucault's insight into the genealogy of subjugated knowledges was helpful in prompting the following questions that I asked of the data in this final chapter: *What are the temporal factors that are structuring acute care organizations in society? What are the beliefs about knowledge, patient care, and resources? What are the intersections and divergences amongst these?* This ethnographic study informed by Foucault's critical perspectives extended existing knowledge of social and organizational structures and processes of acute care settings and how these have an impact on nurses' ACP practices with patients.

In order to understand the multiple factors influencing nurses' practice, findings from this study were conceptualized at the micro, meso, and macro levels. Chapter 4 (micro level) described the everyday work of nurses and their ACP practices. In Chapter 5 (meso level), my analysis focused on the organizational and operational factors that imposed order and structure on nurses' ACP work. In Chapter 6 (macro level) I turned my attention to the larger forces operating within health care that helped me to understand the challenges that nurses experience enacting ACP within the current health care climate. Although the micro, meso, and macro levels were presented in a linear way, acute care nursing practice is multi-layered, complex, and not at all linear. Indeed, as shown in this study, several factors at the micro, meso, and macro levels coalesced to shape the capacity of nurses to engage in ACP within the contemporary health care context.

Descriptions of the realities of acute care nursing practice suggest that ACP is almost impossible to enact within the context of time restraints, juggling care of complex critically ill and ALC patients, the prioritization of medical tasks, while also managing changing clinical assignments and mentoring new and inexperienced nursing colleagues. Given this context, several nurse participants described feeling unprepared and unable to talk with their patients about sensitive and time-consuming subjects. In managing their heavy workloads, nurse participants explained that they prioritized the acute medical nursing tasks essential to the recovery of patients, and those that were legitimized by organizational goals, values, and strategic directions. Participants also stated that their work environment was not conducive to ACP discussions because that environment was shaped by organizational goals, structures, and processes aimed to meet performance standards for funding-related metrics such as high patient flow, capacity, and discharges. Since ACP did not have a direct association with these metrics, there were few processes, structures, or resources to support its implementation, and it was not initiated by nurses. Even in situations where perhaps a patient may have benefited from ACP, such as patients with progressive illness, at the end of life, or admitted as an ALC patient, nurse participants felt that they had little power or voice in organizational decision-making to advocate for its importance to patient-centred care.

In this final chapter, I situate the findings in contemporary health care issues including the organizing effect of the business model on health care, the disappearance of patient-centred care, and the deterioration of nurses' agency.

7.1 The Organizing Effect of the Business Model on Health Care

Health care in Canada is influenced by the values of business operations, such as productivity, efficiency, and performance evaluations (Armstrong & Armstrong, 2003;

Armstrong et al., 2001; Spence Laschinger et al., 2001). In turn, these values have had an impact on patient care, resources, and nursing work. There has been much written in the literature around how business models have influenced, and indeed infiltrated modern health care in Canada. Some researchers describe the use of business model concepts of efficiency and resource management in health care as *the churn of health care organizations* and *the efficiency project* (Gordon, 2005; Rankin, 2009; Rankin & Campbell, 2006) or *new public management* (Griffith & Smith, 2014; Hood, 1995), and cite examples of how the efficiency of nurses' work is measured using management practices such as time studies (Gordon, 2005). Many researchers highlight the ways in which the Canadian health care system is aligned with performance and evaluation metrics associated with funding and the conservation of resources, rather than patient-centred care and personalizing the proper placement of patients (Armstrong & Armstrong, 2003; Armstrong et al., 2001; Choiniere, 2011; Harvey et al., 2020; Rankin, 2003; Rankin & Campbell, 2009; Rudge, 2013). Other scholars are able to describe the impact of the adoption of business priorities in health care on patient care, nurses' work, and the nursing workforce in acute care settings (Shannon & French, 2005). One such consequence is that more nurses are leaving their acute care nursing roles for employment in other sectors, or leaving the profession completely (McGillis Hall & Visekruna, 2020). These departures, it is argued, are due to a lack of support in the acute care sector, extremely heavy workloads, lack of resources, inability to provide care consistent with nursing standards, moral distress, understaffing, and undervaluing of the important work that nurses do to sustain a health care system in need of reform (Gaudine & Thorne, 2012; Maunder et al., 2021; McGillis Hall & Visekruna, 2020; Shah et al., 2021). Acute care nurses who continue to work in this environment ration their care and skip clinical tasks in order to manage their workloads (Harvey et al., 2020; Harvey et al., 2018; Rudge, 2013; Verrall

et al., 2015). Consequently, patients are less satisfied with the care that they receive in hospital settings (Aiken et al., 2000; Aiken et al., 2014).

The organizing effect of the business model on health care was described by participants in my study. Many participants described the ways in which their organizations and units were structured to maximize efficiency by increasing patient flow and discharge in order to meet hospital performance metrics in the goal of securing financing for the following year. For instance, data from observational field notes and interviews with nurses and administrators revealed how non-clinical spaces such as hallways and patient lounges were regularly used to care for patients when they were at overcapacity on their unit to maintain patient flow and discharges.

Nurses' workloads and practice decisions were also impacted by the organizational prioritization of acute care medical treatments, procedures, and tasks that promoted the efficient flow of patients into and out of the hospital setting. In order to adapt to these performance metrics, nurse participants stated that they adjusted their practice to manage organizational goals. For instance, nurse participants in my study felt that they had to rearrange their plan of care to complete medical tasks and treatments first in the day so as to promote patient discharges (even when they felt that patients might not quite be ready to be discharged), skip breaks or lunches, not attend unit meetings, and forgo other relational practices like ACP that were not aligned with organizational priorities. The need to adjust one's practice in order to meet the organizational needs for bureaucratic efficiencies and productivity is found elsewhere in the literature. In her ethnographic study, Selberg (2013) found that the conditions and intensity of acute care nurses' work aligned with neoliberalist organizational priorities such as efficiency, cost containment, and conservation of resources. Evidence of the adoption of business practices in health care can also

be seen by the ratio of indirect versus direct care that occupy the workload of acute care nurses. In my study, one nurse described her practice decisions about workload ratio as: “what little time I am able to spend with my patient, I have to get the necessities done.” Literature supports that acute care nurses spend the majority of their workload on indirect care that takes place outside of the patient room (Aiken et al., 2000; Schenk et al., 2017). Similarly, Hobgood et al. (2005) found that acute care nurses engaged their patients in direct care for approximately 25% of their work day, and spent 75% of their time on indirect patient care tasks such as charting, collecting supplies, and gathering medications. These studies reinforce the findings in my study that several aspects of patient-centred care have been lost to make way for efficient and productive care processes.

7.2 The Loss of Patient-Centred Care in Acute Care Settings

The taken-for-granted global discourse that acute care organizations should adopt bureaucratic priorities has had detrimental effects on patient-centred care in acute care settings. Fundamentally, patient-centred care is widely considered to have positive outcomes on patient care and satisfaction (Rathert et al., 2012). Although patient-centred care has no agreed-upon definition, the Institute of Medicine offers that the hallmark characteristics of patient-centred care are to respect and respond to the needs, preferences, and values of the individual in relation to their clinical treatment (Institute of Medicine, 2001). Najafizada et al. (2021) add that patient-centred care involves a respect for the patient’s dignity and autonomy, integration of the patient’s perspectives into their services, and relationally engaging patients in their care. Thorne and Stajduhar (2017) highlight that patient-centred care involves tailoring and personalizing one’s care of a patient that might require a nurse to “take a course of action that departs from what might serve most persons under similar circumstances” (p. 26).

Working within the business model of health care, patient-centred care often became an elusive goal for nurses to achieve. While nurse participants understood the importance of patient-centred care, study findings suggested that the type of care that nurses desired to provide was not always consistent with what they were able to provide on a day-to-day basis. Many nurse participants described how the business goals of efficiency and productivity have pushed out patient-centred care in that the hospital environment offered little privacy for patients, few experienced nursing staff, scant resources (i.e., education on relational practice skills such as ACP), and a fast-paced, stressful, hectic setting where many nurses were constantly running to "put out fires" to keep the system running. One nurse participant noted that they do not have time for patient-centred care:

> We just seem so rushed. It's more like spot care - kinda putting out fires rather than tending to their [patient's] needs or the needs of the family. We are just so busy. Our environment is dynamic and unpredictable, it seems like we are just putting out fires and not really having the time to spend one on one with anybody. I do sit and talk to them, but not like I used to, like, those things don't worry me as much anymore, like it's more like did the task get done? This bothers me to no end.

It was common to hear participants describe the structure and operation of their units as being heavily influenced by an organizational emphasis on patient flow, strategic planning goals, accreditation demands, and a *fix-it* culture. Working within this context, nurses described their work as *juggling* and *scrambling* to complete tasks while *balancing* their time. In order to manage, nurses spoke of prioritizing medical tasks and procedures while leaving other relational and communication-based tasks undone (i.e., ACP). These findings are consistent with studies conducted by Aiken et al. (2000), Karra et al. (2018), Müller et al. (2021), and Kwame and Petrucka (2021), where researchers found that institutional commitments to individualized,

relational patient-centred care was undermined by bureaucratic goals, as seen by workload characteristics such as overcapacity, time restraints, and task-centred care.

Since nurses were expected to prioritize tasks that resulted in the reduction of the patient's length of stay (Harvey et al., 2020; Rankin & Campbell, 2006), many nurse participants in this study spoke about having to ration their nursing care as a strategy to manage the bureaucratic push for efficiency in the clinical setting. Harvey et al. (2018) and Verrall et al. (2015) unpacked how nurses made decisions about which nursing care tasks would be left undone and how they would ration their time with patients. They found that nurses considered the priorities of the organization and the needs of the patient in determining how to best spend their clinical time with patients as they juggled heavy workloads and insufficient human resources. This deprioritization of patient-centred care might help explain why nurses in this study described a setting in which supporting relational ACP was impossible. I argue that the good intentions of acute care settings to address health care needs of community members are undermined by the uncritical acceptance of a globally taken-for-granted discourse that health care systems should adopt bureaucratic priorities. This global discourse has detrimental effects on patient-centred care and nurse agency.

7.3 The Deterioration of Nurse Agency Over Their Practice

Program management philosophy advocates that a particular set of managerial skills should drive decision-making within health care organizations (Heslop & Francis, 2005). Within the current dominant discourse that health care systems and organizations should adopt a business model, there has been a corresponding loss of patient-centred care, and a subjugation of knowledge and voices in the process (Foucault, 1980; Rudolph, 2017). In particular, nurses' knowledge, expertise, and insight is suppressed in decision-making circles, and the knowledge

that is being used to inform decisions and structure the context of care is a result of political power relations directly linked to the financing of acute care. Scholars agree that nurses' voices at administrative decision-making levels in acute care settings have been progressively silenced over the past 20 years (Clarke et al., 2001; McMillan, 2016; Shamian, 2016; Thorne, 2021; Thorne & Stajduhar, 2017).

Many nurse participants in my study spoke about how little control they had over their own practice decisions or unit decisions about patient care because there were no strategies used by their managers to gather their opinions, insight, or experience about unit initiatives. This was very frustrating for participants as they felt that their expertise was unrecognized, knowledge was devalued, and input was unappreciated. Specifically, nurse participants felt frustrated in not being able to speak out or take action against the prioritization of accreditation standards, funding metrics, patient flow, and tasks on their unit or on the misalignment of their nursing care with personal values, professional standards, and patient needs. This is consistent with the findings from existing research studies showing that the loss of nurse agency over their day-to-day practice decisions leaves them feeling morally distressed (McMillan, 2018; Papastavrou et al., 2014; Rankin, 2009; Schluter et al., 2008). For example, many nurse participants agreed that ACP was a critical component of care for those with progressive life-limiting illnesses, and that many of their patients were on a trajectory toward death, but they were frustrated that they could not offer ACP due to resource limitation and competing demands on their time.

Although many nurses described that they had to prioritize, ration, and/or forgo certain aspects of their work in order to survive their shift, these too were strategies that enabled nurses to unwittingly participate and reinforce the dominant discourses that were organizing and structuring their work. Imagine if the workplace could be different – if organizations and health

care systems prioritized the values of universal, accessible, personalized, high quality health care for all. Recognizing what could be is an important step to appreciate what the end goal could be in changed circumstances.

7.3.1 Platform for Nurse Agency in ACP

In her 2009 publication, Rankin (2009) encouraged nurses to not accept the status quo, but to push back against the ideologies of their health care system and acute care organization by engaging in consciousness-raising groups and being a driver for system transformation. An example of what this might look like is presented here using the scenario of ALC patients in acute care settings.

In Canada, the number and proportion of older individuals is growing, and it is expected to continue in coming years. In 2020, there were 6.8 million adults aged 65 years and over, representing 18% of the total Canadian population (Statistics Canada, 2020). Prediction models suggest that this proportion will continue to increase, with the most rapid rate of increase occurring until 2030 (Statistics Canada, 2019b) as the baby boomer cohort begins to enter this age group. The aging population presents a challenge for the provision of care in Canada as the complex health, social, and functional needs of older adults is taking place within a system of strained health care budgets and limited household means. As it is, the demand for home and community care services today is already unprecedented, with more than 40,000 Canadians on wait lists for nursing homes, and expectations of this demand to grow as the population ages (National Institute on Ageing, 2019). In part, this is because when the Canada Health Act (Government of Canada, 1985) was created, it focused on the provision of hospital and physician services and did not award universal provision of long-term care or home care for Canadians. This has resulted in a lack of home and community-based care for older adult populations who

need support from the health care system. Although funding for long-term care and home and community-based care was not declared in the Canada Health Act, Canadian provinces and territories have established ways to fund some of the needs of the aging population, but it has not kept pace with the volume of patient needs, and it remains unclear what amount and type of care will be publicly supported in the long term (National Institute on Ageing, 2019). The lack of attention to, and planning for, the needs of an aging population in Canada means that many Canadians in need of care are placed in hospital beds, awaiting placement elsewhere (Gibbard, 2017), but the shortage of beds in the system is exacerbating the crisis of hallway medicine.

In my study, nurses spoke about the large number of ALC patients admitted on their units. One nurse participant working on a medical unit described what she called the "*ALC crisis in acute care*." She recounted that "we are anywhere between 95 to 110 ALC patients in here every day out of 500 beds." An administrator of an acute care centre provided her account as to why there were so many ALC patients:

> Hospital patients should be able to move out of that acute care setting when they no longer need that level of care, into long-term care settings, home care settings, or retirement homes with home care support/assisted living. We have done really well keeping people alive a lot longer, but this means that there are a whole lot of aging people with chronic needs and we just haven't evolved the systems outside of hospitals to allow them to live well in other settings. So it's really a structural issue, we have organized the health care system around acute care and as the needs have shifted to chronic care, we have not moved quickly enough.

This account highlights some of the structural issues in the Canadian health care system that are in dire need of reform, including consideration of how community-based and long-term care models are expanded, funded, and designed to meet the needs of any aging population. Without such reforms, patients who could benefit from integrating approaches aligned with

chronic disease management and palliative approaches to care, for example, will continue to be cared for in acute care hospitals with care that deprioritizes patient-centred care and valuing interventions such as ACP that could vastly improve the quality of living and dying for many older Canadians.

In my study, nurses spoke of the care that they need to provide ALC patients as "…that's not what I signed up for," and these patients were portrayed as getting in the way of their care of specialty patients. Nurses also spoke of how these patients are so unwell that it is not appropriate for nurses to have ACP conversations with them due to their limited energy and high pain levels. However, the reality is that these patients are in the acute care system, and they are arguably in great need of ACP to ensure that their end of life wishes are consistent with their medical treatments. Perhaps this is a platform that nurses can advocate for change: the importance of ACP with all ALC patients.

In the final section of the dissertation, I state the conclusions that arose from my study findings and pose recommendations for practice, education, administration, research, and policy development.

7.4 Conclusions

What I learned from the findings of this study is that, given the current acute care context within which nurses are working, nurses feel that it is unrealistic to expect them to be able to engage patients in their ACP. Based on my interpretations of the data from this study, I put forward the following conclusions:

1. There are various individual, organizational, and societal factors that are working in a concerted way to govern the practice of nurses in acute care settings.

2. One of the powerful influencers that shape nurses' work are the values of efficiency and productivity that underpin businesses.
3. The preoccupation with the business model of health care has pushed out patient-centred care and associated relational practice such as ACP, but it has also led to the silencing of nurses.
4. Nurses do not routinely engage their patients in ACP.
5. Nurses may begin to take back their agency by advocating for the need of ACP with ALC patients.

These conclusions provide a grounding to make recommendations on nursing practice, education, administration, policy, and research.

7.5 Recommendations

7.5.1 Nursing Practice

Nurse participants stated that they value ACP, but that this conversation cannot be initiated with ALC patients admitted on acute care units because, as one medical nurse described it:

> They are in extreme pain, and have high levels of narcotics in their system to manage it, so they aren't able to reflect on these high level conversations and they do not have the energy or focus on [ACP]. They are worried about their admission diagnosis. It is not the place to start asking questions about the future when they have to prioritize the energy that they have today, on dealing with today.

Arguably, though, there will likely be increasing ALC admissions in the next 20 years, as the baby boomer population ages and long-term care or community care resources cannot keep up. It might also be argued by some that the ALC population is exactly the group that would benefit most from ACP conversations as they anticipate upcoming treatment decisions and what they would choose the end of life to be like. Advocating for the worth of ACP for ALC patients

might be a valuable platform for nurses to promote with administrators of their acute care settings. In this way, nurses will be able to work together to support patients to have a conversation that would be relevant to their stage of health. Such an initiative could lead to the establishment of ground-breaking policies and procedures to enable ACP processes in acute care. In this study, participants stated, “we have some of those [ALC] patients everywhere” and “we have ALC patients across the whole hospital,” so advocating for ACP for these patients might create unity amongst acute care nurses to initiate a change in their organization for the betterment of patient care.

7.5.2 Nursing Education

Data from this study described the context within which nurses work on acute care units. Some participants described that many of the beds on their specialty unit are occupied by medical patients: “at least 40% of my patients each day are medical. We just don’t have enough beds for our medical patients on our units,” and others described that they are unmanageably busy as they scramble to get things done and run from patient to patient putting out fires. This is important information for nurse educators as they are preparing students to enter into this context, and students need to have the skills to be able to cope. The implications are great for nurse educators in light of this information. For instance, most nursing curricula have some focus on nursing leadership, relational practice, and patient-centred care. Educators must reflect on how they can best prepare students for the reality of what these concepts mean in today’s acute care setting, and how to teach them in ways that are useful for nursing students. One nurse participant in this study spoke of the mismatch between what she was taught in school and what she is managing in the workplace:

> It's not what we learned in school. We learned to always look after that patient holistically and…we are very task-oriented nurses now. When I come home, I am thinking about the tasks that I did and not the emotional support that I gave the patient.

Undergraduate nursing programs may also mirror the organization of acute care hospitals in that they offer courses focusing on specialties such as cardiac care, oncology, respiratory care, and orthopedics. While specialty content is important for students to learn, data from this study supports that almost half of patient admissions primarily have medical diagnoses (such as uncontrolled diabetes), even on the specialty units. Therefore, educating students in a silo fashion about specialties in their undergraduate, graduate, or professional training may not prepare them for the reality of who is in their assigned beds today. One cardiology nurse described this well:

> The medical patients usually have a lot more going on and being on the cardiology unit, we have been taught a lot of the cardiology stuff and less medical so when things happen that we really don't know what we are doing it makes it difficult and you kinda have to educate yourself as you go sometimes.

Similarly, undergraduate education programs are based on the assumption that nurses are advocates for their patients in the acute care setting. Data from this study suggested that nurses did not feel they were able to give voice to their own concerns, nor those of their patients in their workplaces. Nurse educators might reflect on how to best teach students to be an advocate in a system where nurses might feel that their voice, experience, and input is not actively sought by decision-makers.

7.5.3 Acute Care Administrators

Distress about the acute care work environment was a prominent concern for participants in this study. Literature supports that this is important to consider in reducing nurse burnout because there is an inverse relationship between quality of acute care work environment and nurse burnout (Brooks Carthon et al., 2021). Many nurses in this study spoke about their

exhaustion and frustration in their work setting, commonly describing feelings of panic, feeling frazzled, and like they are drowning: “it takes its toll on me. I don’t feel supported, I feel alone. I can’t wait to get out of here.” Nurses need more support from their leaders in order to cope. The feeling of burnout is common in acute care nursing, being reported by one in every three acute care nurses (Brooks Carthon et al., 2021). Some of the sources of their burnout cited in the literature are heavier workloads, increased patient acuity, time pressures, and limited resources (Maunder et al., 2021). My study corroborated these themes, where participants cited feelings of distress about their inability to care for patients as they felt they should, and not being able to maintain their nursing standards of care and use best evidence in their practice. Health care administrators are encouraged to consider the health of the acute care workplace and consider how the organization might reduce nurse burnout, improve patient satisfaction, and assess whether there are additional, efficient ways to support nurses. According to participants from my study, suggestions for unit administrators were to enhance communication and partnership between unit managers and nurses, seek recommendations and input from clinicians about initiatives on their unit, and provide regular debriefing. One nurse working on the cardiology unit also suggested that more of a presence on the unit might be beneficial:

> We feel like management staff do not understand the work of nurses. Maybe it would be helpful to have them shadowing us a few days every few months to see what impacts our practice and our patients. Then we might feel more confident that patient need and quality of care is bring prioritized in their meetings and decisions.

These recommendations for acute care administrators might be useful in addressing the systemic nature of silencing that nurses experienced in this study, and it may reduce the feelings of burnout and distress of acute care nurses.

The findings from my research study also call upon acute care administrators to recognize how the organizational policy and processes flow through them, ultimately governing the practices of the nurses on their unit. Similar to the nurses they manage, literature shows that Canadian nurse managers of acute care units feel overwhelmed by responsibilities, bound by managerial technologies, accountable for organizational efficiencies, and unable to provide input from their nursing experience (Fast, 2016; Fast & Rankin, 2018). In my study, one administrator spoke about how, at a meeting of unit managers and administrators, she volunteered to take on a pilot project because "as a manager you tend to look for improvement work within your unit that's meaningful and would make a difference." Although it may not outwardly seem that the priorities set by unit managers have limited relevance for front-line staff and patient care, staff are making significant efforts to understand what the initiatives are trying to accomplish, and they are attempting to align their work and care with those priorities. Recommendations from the findings in this study encourage administrators to recognize the powerful influence that they continue to have over the way in which nursing practice is governed on their unit as determined by the policies that they support.

My findings also call for acute care administrators to consider the ways in which they can support the legitimacy of ALC patients on their units. Interview data from various participants indicated that nurses felt that the care of ALC patients was "taking away from my other patients" because "you are not here for medical reasons, you don't really need my care." As a result, "they get less of everything, less care, because everybody is focused on the acute patients coming through the door," and nurse participants admitted that they are "not as personable with them." Realistically, though, these are the patients that are populating acute care beds today, and they are in need of planned care for the long term, which is an ideal scenario for ACP. Perhaps unit

administrators may be able to advocate for policies and processes that support the legitimacy of these patients on acute care units in order to improve the quality of care that they receive.

7.5.4 Health Policy

In addition to organizational level solutions to improving work environments, there must be a review of the values that shape and govern health care systems in Canada and, in particular, acute care funding. As seen above, there are multiple examples of where participants state that the structure and processes on their units prioritize efficiency and productivity. Health policy makers are encouraged to reflect on a topic posed by Gordon (2005): Within the churn for efficiency in managing health care money, is there room to more effectively manage care? Surely, we all agree that health care resources need to be managed efficiently, but perhaps there needs to continue to be a discussion of the most effective way to manage these dollars while reinstituting patient-centred care and patient safety as foundational concepts. This may require reflections on how we got to the place where efficiency in health care pushed these concepts to the background.

Although there is already widespread recognition of the need for change in Canada's health care system, and some are calling for greater focus on preventative, restorative, and optimizing quality of care (Canadian Academy of Health Sciences, 2010), there needs to also be a call for a system level analysis to determine adequacy of community, home, and long-term care resources. As stated in the findings, participants state that they routinely worked in overcapacity, were understaffed, and had many ALC patients. In fact, one nurse explains, "it feels sometimes like we have nursing home assignments with a lot of ALC's or we have many medical patients even though we are a cardiac unit." There are currently many patients in acute care who would be better served by an alternative form of care. Improvements to health policy calls for an

assessment of the adequacy of resources for home, community, and long-term care relative to patient needs, with an end goal of preventing these patients from unnecessary hospitalizations.

Finally, health policy makers are encouraged to consider the most effective ways to organize hospital units. Historically, acute health care units have been organized as specialty units such as oncology, cardiology, and so on. It may be worth a consideration if organizing acute care units by specialty is meeting the needs of acute care patients today. In this study, participants regularly stated that, although they feel most comfortable caring for patients who *fit* on their specialty units, more than half of their patients were general medicine or ALC. One participant reflected that the idea of specialty units is not applicable to acute care units today: "the type of patient that we would get, it's just, they are not fun to look after, someone's just gotta do it; you know when you have signed up for being a specialty nurse, it almost just doesn't exist anymore." Another nurse spoke of how she had specialized training to care for the patients on her specialized unit, but felt mislead when she had to care for medical patients instead:

> I didn't sign up to look after that, but if there is no room anywhere else, then they end up being on our floor; we get the elderly who come in with urinal stuff and they are confused and that's not what I signed up for.

Health policy makers are encouraged to consider the way in which acute care hospitals have been organized historically, and assess if this is the most effective way to care for the population that it is serving today.

7.5.5 Nursing Research

On the whole, data from this study found that there was a great deal of resistance to implementing ACP in acute care practice, even though it is considered by many to be a good intervention (Jimenez et al., 2018; McMahan et al., 2020; Reitjens et al., 2017; Starr et al., 2019). This is not new; other researchers also note the resistance to change and impenetrability of the

Canadian health care system (Thorne & Stajduhar, 2017) but there is little that we know about the factors that will influence our health care system to change, and those that make the system so resilient.

7.6 Summary

In conclusion, this study explored the influence of organizational acute care contexts on nurses' ACP practices. The findings show that there are many factors that work in concert to impose order and structure on nurses' acute care work such that nurses feel that ACP is almost impossible to enact in their practice. While many participants in this study recognized the benefits of ACP for their patients, they could not foresee how it could be integrated into their work given the context of acute care settings. The findings from this study indicate that there is a need to re-conceptualize the ways in which acute care nurses engage their patients in ACP with consideration of contemporary health care issues.

References

Aiken, H. L., Clarke, P. S., & Sloane, M. D. (2000). Hospital restructuring: Does it adverse affect care and outcomes? *JONA: The Journal of Nursing Administration, 30*(10), 457-465.

Aiken, L. A., Sloane, P. D., Bruyneel, L., Van den Heede, K., Griffiths, P., Busse, R., Diomidous, M., Kinnunen, J., Kozka, M., Lesaffre, E., McHugh, M. D., Moreno-Casbas, M. T., Rafferty, A. M., Schwendimann, R., Scott, P. A., Tishelman, C., van Achterberg, T., & Sermeus, W. (2014). Nurse staffing and education and hospital mortality in nine European countries: A retrospective observational study. *The Lancet, 6736*(13), 62631-62638. https://doi.org/10.1016/S0140-6736(13)62631-8

Allen, D. (2014). Re-conceptualizing holism in the contemporary nursing mandate: From individual to organizational relationships. *Social Science & Medicine, 119*, 131-138.

Allen, D. (2015). Inside 'bed management'; ethnogrphic insights from the vantage point of UK hospital nurses. *Sociology of Health & Illness, 37*(3), 370-384.

Armstrong, P., & Armstrong, H. (2003). *Wasting away: The undermining of Canadian health care* (2nd ed.). Oxford University Press.

Armstrong, P., Armstrong, H., & Coburn, D. (2001). *Unhealthy times: Political economy perspectives on health and care in Canada*. Oxford University Press.

Arnett, K., Sudore, R. L., Nowels, D., Feng, C. X., Levy, C. R., & Lum, H. D. (2016). Advance care planning: Understanding clinical routines and experiences of interprofessional team members in diverse health care settings. *American Jounal of Hospice and Palliative Medicine, 34*(10), 946-953.

Atkinson, P. (2015). *For ethnography*. Sage.

Atkinson, P., Coffey, A., Delamont, S., Lofland, J., & Lofland, L. (2011). *Handbook of ethnography*. Sage.

Atkinson, P., & Hammersley, M. (1994). Ethnography and participant observation. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 248-261). Sage Publications.

Baggs, J. G., Norton, S. A., Schmitt, M. H., Dombeck, M. T., Sellers, C. R., & Quinn, J. R. (2007). Intensive care unit cultures and end-of-life decision making. *Journal of Critical Care, 22*(2), 159-168.

Baughman, K. R., Ludwick, R., Palmisano, B., Hazelett, S., & Sanders, M. (2015). The relationship between organizational characteristics and advance care planning practices. *American Journal of Hospice & Palliative Care, 32*(5), 510-515.

Bernard, H. R. (2001). *Research methods in anthropology: Qualitative and quantitative approaches*. AltaMira Press.

Black, K. (2006). Advance directive communication: Nurses' and social workers' perceptions of roles. *American Journal of Hospice & Palliative Medicine, 23*(3), 175-184. https://doi.org/10.1177/1049909106289080

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Sage.

Boyd, D., Merkh, K., Rutledge, D. N., & Randall, V. (2011). Nurses' perceptions and experiences with end-of-life communication and care. *Oncology Nursing Forum, 38*(3), E229-E239.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. Sage.

Braun, V., & Clarke, V. (2021). To saturate or not to saturate? Questioning data saturation as a useful concept for thematic analysis and sample-size rationales. *Qualitative Research in Sport, Exercise and Health, 13*(2), 201-216.

Brinkman-Stoppelenburg, A., Rietjens, J., & van der Heide, A. (2014). The effects of advance care planning on end-of-life care: A systematic review. *Palliative Medicine, 28*(8), 1000-1025.

Brooks Carthon, M. J., Hatfield, L., Brom, H., Houton, M., Kelly-Hellyer, E., Schlak, A., & Aiken, L. H. (2021). System-level improvements in work environments lead to lower nurse burnout and higher patient satisfaction. *Journal of Nursing Care Quality, 36*(1), 7-13. https://doi.org/10.1097/NCQ.0000000000000475

Burbank, P. M., & Martin, D. C. (2009). Symbolic interactionism and critical perspective: Divergent or synergistic? *Nursing Philosophy, 11*, 25-41.

Cadge, W., Lewis, M., Bandini, J., Shostak, S., Donahue, V., Trachtenberg, S., Grone, K., Kacmarek, R., Lux, L., Matthews, C., McAuley, M. E., Romain, F., Snyderman, C., Tehan, T., & Robinson, E. (2021). Intensive care unit nurses living through COVID19: A qualitative study. *Journal of Nursing Management, 29*(7), 1965-1973. https://doi.org/10.1111/jonm.13353

Canadian Academy of Health Sciences. (2010). *Transforming care for Canadians with chronic health conditions: Put people first, expect the best, manage the results*. http://www.cahs-acss.ca/wp-content/uploads/2011/09/cdm-final-English.pdf

Canadian Association of Schools of Nursing. (2011). *Palliative and end-of-life care: Entry-to-practice competencies and indictors for registered nurses*. C. A. o. S. o. Nursing.

Canadian Hospice Palliative Care Association. (2013). *What Canadians say: The way forward Survey Report*. http://www.hpcintegration.ca/media/51032/The%20Way%20Forward%20-%20What%20Canadians%20Say%20-%20Survey%20Report%20Final%20Dec%202013.pdf

Canadian Nurses Association. (2015). *Joint position statement:The palliative approach to care and the role of the nurse*. https://www.virtualhospice.ca/Assets/A%20Palliative%20Approach%20to%20Care%20and%20the%20Role%20of%20the%20Nurse_20151001151135.pdf

Carspecken, P. F. (2001). Critical ethnographies from Houston: Distinctive features and directions. In P. F. Carspecken & G. Walford (Eds.), *Critical ethnography in education: Studies in educational ethnography* (pp. 1-26). Emerald Group Publishing Limited.

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328.

Catlin, B. J., Lewis, K. B., Nichols, N., & Parsons, L. M. (2015). Advance care planning and the role of the cardiovascular nurse. *Canadian Journal of Cardiovascular Nursing, 25*(3), 5-9.

Chan, L. S., Macdonald, M. E., Carnevale, F. A., & Cohen, S. R. (2018). 'Im'm only dealing with the acute issues': How medical ward 'busyness' constrains care of the dying. *Health, 22*(5), 451-468. https://doi.org/10.1177/1363459317708822

Choiniere, J. A. (2011). Accounting for care: Exploring tensions and contradictions. *Advances in Nursing Science, 34*(4), 330-344.

CIHI. (2021). *Hospital stays in Canada*. https://www.cihi.ca/en/hospital-stays-in-canada

Clancy, M. (2013). Is reflexivity the key to minimising problems of interpretation in phenomenological research? *Nurse Researcher, 20*(6), 12-16.

Clark, K., Cain, J., Campbell, L., & Byfieldt, N. (2015). Caring for people dying in acute hospitals: A mixed-methods study to examine relative's perceptions of care. *Palliative and Supportive Care, 13*, 335-343.

Clarke, A., & Ross, H. (2006). Influences on nurses' communications with older people at the end of life: Perceptions and experiences of nurses working in palliative care and general medicine. *International Journal of Older People Nursing, 1*(1), 34-43.

Clarke, H. F., Spence Laschinger, H. K., Giovannetti, P., Shamian, J., Thomson, D., & Tourangeau, A. (2001). Nursing shortages: Workplace environments are essential to the solution. *Hospital Quarterly, 4*(4), 50-56.

Clifford, J. (1990). Notes on (Field)notes. In R. Sanjek (Ed.), *Fieldnotes* (pp. 47-70). Cornell University Press.

Clifford, J., & Marcus, G. E. (Eds.). (1986). *Writing culture: The poetics and politics of ethnography*. University of California Press.

Connors, A. F. J., Dawson, N. V., Desbiens, N. A., Fulkerson, W. J. J., Goldman, L., Knaus, W. A., Lynn, J., & Oye, R. K. (1995). A controlled trial to improve care for seriously ill hospitalized patients: The study to understand prognoses and preferences for outcomes and risks of treatment (SUPPORT). *Journal of the American Medical Association, 274*(20), 1591-1598.

Constantinou, C. S., Georgiou, M., & Perdikogianni, M. (2017). A comparative method for themes saturation (Comets) in qualitative research. *Qualitative Research, 17*(5), 571-588. https://doi.org/doi:10.1177/1468794116686650

Creswell, J. W., & Poth, C. N. (2018). *Qualitative inquiry & research design: Choosing among five approaches* (4th ed.). Sage.

DeCourcey, D. D., Partin, L., Revette, A., Bernacki, R., & Wolfe, J. (2021). Development of a stakeholder driven serious illness communication program for advance care planning in children, adolescents, and young adults with serious illness. *The Journal of Pediatrics, 229*, 247-258.

Denzin, N. K., & Lincoln, Y. S. (2011). *The SAGE handbook of qualitative research* (4 ed.). Sage.

Detering, K. M., Hancock, A. D., Reade, M. C., & Silvester, W. (2010). The impact of advance care planning on end of life care in elderly patients: Randomised controlled trial. *British Medical Journal, 340*(1345), 1-9.

Detering, K. M., Sinclair, C., Buck, K., Sellars, M., White, B. P., Kelly, H., & Nolte, L. (2021). Organisational and advance care planning program characteristics associated with advance care directive completion: A prospective multicentre cross-sectional audit among health and residential aged care services caring for older Australians. *BMC Health Services Research, 21*, Article 700. https://doi.org/doi.org/10.1186/s12913-021-06523-z

Dixon, J., & Knapp, M. (2018). Whose job? The staffing of advance care planning support in twelve international healthcare organizations: A qualitative interview study. *BMC Palliative Care, 17*. https://doi.org/https://doi.org/10.1186/s12904-018-0333-1

Drought, T. S., & Koenig, B. A. (2002). "Choice" in end-of-life decision making: Research fact or fiction? *The Gerontologist, 42*(Special issue 11), 114-128.

Duke, G., & Thompson, S. (2007). Knowledge, attitudes and practices of nursing personnel regarding advance directives. *International Journal of Palliative Nursing, 13*(3), 109-115.

Emerson, R. M., Fretz, R. I., & Shaw, L. L. (1995). *Writing ethnographic fieldnotes*. University of Chicago Press.

Fast, O. (2016). *The social organization of staffing work of nurse managers: A critique of contemporary nursing workload technologies* [Doctoral dissertation, University of Calgary]. Calgary, Alberta.

Fast, O., & Rankin, J. (2018). Rationing nurses: Realities, practicalities, and nursing leadership theories. *Nursing Inquiry, 25*(2), Article e12227. https://doi.org/DOI: 10.1111/nin.12227

Fliedner, M., Halfens, R. J. G., King, C., Eychmueller, S., Lohrmann, C., & Schols, J. M. (2021). Roles and responsibilities of nurses in advance care planning in palliative care in the acute care setting: A scoping review. *Journal of Hospice & Palliative Nursing, 23*(1), 59-68.

Foucault, M. (1966). *The order of things: An archeology of the human sciences*. Tavistock.

Foucault, M. (1967). Who are you, Professor Foucault? In J. R. Charrette (Ed.), *Religion and culture* (pp. 87-103). Manchester University Press.

Foucault, M. (1975). *Discipline & punish: The birth of the prison* (A. Sheridan, Trans.). Vintage Books.

Foucault, M. (1978). Governmentality. In J. D. Faubion (Ed.), *Power* (pp. 202-222). The New Press.

Foucault, M. (1980). Two lectures. In C. Gordon (Ed.), *Michel Foucault power/knowledge: Selected interviews and other writings 1972-1977 by Michel Foucault*. Pantheon Books.

Funk, L. M., & Stajduhar, K. I. (2009). Interviewing family caregivers: Implications of the caregiving context for the research interview. *Qualitative Health Research, 19*(6), 859-867. https://doi.org/10.1177/1049732309334105

Gagnon, J., & Duggleby, W. (2014). The provision of end-of-life care by medical-surgical nurses working in acute care: A literature review. *Palliative & Supportive Care, 12*(5), 393-408.

Gassas, R. (2021). Sources of the knowledge -practice gap in nursing: Lessons from an integrative review. *Nurse Education Today, 106*. https://doi.org/doi.org/10.1016/j.nedt.2021.105095

Gaudine, A., & Thorne, L. (2012). Nurses' ethical conflict with hospitals: a longitudinal study of outcomes. *Nursing Ethics, 19*(6), 727-737. https://doi.org/10.1177/0969733011421626

Geertz, C. (1973). *The interpretation of cultures*. Basic Books.

Gibbard, R. (2017). *Sizing up the challenge: Meeting the demand for long-term care in Canada*. The Conference Board of Canada. https://www.cma.ca/sites/default/les/2018-11/9228_Meeting%20the%20Demand%20for%20Long-Term%20Care%20Beds_RPT.pdf

Gold Standards Framework. (2010). *Thinking ahead: Advance care planning discussion*. National Gold Standards Framework Center. http://www.goldstandardsframework.org.uk/Resources/Gold%20Standards%20Framework/PDF%20Documents/ACP%20General%20version%20Feb10%20v20.pdf

Gordon, S. (2005). Management by churn. In *Nursing against the odds: How health care cost cutting, media stereotypes, and media hubris undermine nurses and patient care* (pp. 351-383). Cornell University Press. https://doi.org/10.7591/9780801465048

Government of Canada. (1985). *Canada Health Act*. Government of Canada. https://laws-lois.justice.gc.ca/eng/acts/c-6/fulltext.html

Government of Canada. (2014). *Action for seniors report*. https://www.canada.ca/en/employment-social-development/programs/seniors-action-report.html#tc2a.

Government of Ontario. (2010). *Excellent Care for All Act*. https://www.ontario.ca/laws/statute/10e14

Government of Ontario. (2021). *Quality-based procedures*. https://www.health.gov.on.ca/en/pro/programs/ecfa/docs/qbp_fiscal_list_en.pdf

Grant, M. A., Rohr, L. N., & Grant, J. T. (2012). How informants ask questions: Implications for reflexivity. *Field Methods, 24*(2), 230-246.

Griffith, A. I., & Smith, D. E. (2014). *Under new public management*. University of Toronto Press.

Gubrium, J. F. (1988). *Analyzing field reality*. Sage.

Halstead, N. (2001). Ethnographic encounters. Positioning within and outside the insider frame. *Social Anthropology, 9*(3), 307-321. https://doi.org/doi :10.1017/S0964028201000234

Hammersley, M., & Atkinson, P. (2007). *Ethnography: Principles in practice* (3rd ed.). Routledge.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies, 14*(3), 575-599.

Harding, S. (1993). Rethinking standpoint epistemology: What is "strong objectivity"? In L. Alcoff & E. Potter (Eds.), *Feminist epistemologies* (pp. 49-82). Routledge.

Harvey, C., Thompson, S., Otis, E., & Willis, E. (2020). Nurses' views on workload, care rationing and work environments. *Journal of Nursing Management, 28*, 912-918. https://doi.org/DOI: 10.1111/jonm.13019

Harvey, C. L., Willis, E., Meyer, A., & Pearson, M. (2018). Understanding how nurses ration care. *Journal of Health Organization and Management, 32*(3), 494-510. https://doi.org/DOI 10.1108/JHOM-09-2017-0248

Headland, T. N., Pike, K. L., & Harris, M. (1990). *Emics and etics: The insider/outsider debate*. Sage Publications.

Heckel, V., A. R., , Stiel, S., Radon, J., Kurkowski, S., Goebel, S., Ostgathe, C., & Weber, M. (2020). The quality of care of the dying in hospital—next-of-kin perspectives. *Supportive Care in Cancer*, *28*(9), 4527-4537. https://doi.org/https://doi.org/10.1007/s00520-020-05465-2

Hennick, M. M., Kaiser, B. N., & Marconi, V. C. (2017). Code saturation versus meaning saturation: How many interviews are enough? *Qualitative Health Research, 27*(4), 591-608.

Heslop, L., & Francis, K. (2005). Case study of program management in Canada. *Nursing Leadership*, *18*(2). https://doi.org/doi:10.12927/cjnl.2005.19029

Heyland, D. K., Barwich, D., Pichora, D., Dodek, P., Lamontagne, F., You, J. J., Tayler, C. M., Porterfield, P., Sinuff, T., & Simon, J. (2013). Failure to engage hospitalized elderly patients and their families in advance care planning. *JAMA Intern Med*. https://doi.org/doi:10.1001/jamainternmed.2013.180

Higginbottom, G. M. A., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *The Qualitative Report, 18*(9), 1-16, Article 17.

Higginson, I. J., Finlay, I., Goodwin, D. M., Cook, A. M., Hood, K., Edwards, A. G. K., Douglas, H. R., & Norman, C. E. (2002). Do hospital-based palliative teams improve care for patients or families at the end of life? *Journal of Pain & Symptom Management, 23*(2), 96-106.

Hobgood, C., Villani, J., & Quattlebaum, R. (2005). Impact of emergency department volume on registered nurse time at the bedside. *Annals of Emergency Medicine, 46*(6), 481-489.

Hood, C. (1995). The "new public management" in the 1980s: Variations on a theme. *Accounting, Organizations and Society, 20*(2/3), 93-109. https://doi.org/https://doi.org/10.1016/0361-3682(93)E0001-W

Hospice and Palliative Nurses Association. (2011). HPNA Position Statement. The nurse's role in advance care planning. *Journal of Hospice & Palliative Nursing, 13*(4), 199-201. https://doi.org/10.1097/NJH.0b013e3182230a2b

Houben, C. H., Spruit, M. A., Groenen, M. T., Wouters, E. F., & Janssen, D. J. (2014). Efficacy of advance care planning: A systematic review and meta-analysis. *Journal of Am Med Directors Assoc, 15*(7), 477-489.

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK222274/

Izumi, S. (2017). Advance care planning: The nurse's role. *American Journal of Nursing, 117*(6), 56-61.

Jimenez, T., W. S., , Virk, A. K., Low, C. K., Car, J., & Ho, A. H. Y. (2018). Overview of Systematic Reviews of Advance Care Planning: Summary of Evidence and Global Lessons. *Journal of Pain and Symptom Management,, 56*(3), 436–459.e425. https://doi.org/https://doi.org/10.1016/j.jpainsymman.2018.05.016

Jorgensen, D. L. (1989). *Participant observation: A methodology for human studies*. Sage.

Karra, V., Papathanassoglou, E. D., Lemonidou, C., Sourtzi, P., & Giannakopoulou, M. (2018). Exploration and classification of intensice care nurses' clinical decisions: A Greek perspective. *Nursing in Critical Care, 19*(2), 87-97. https://doi.org/doi: 10.1111/nicc.12018

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research, 6*(3), 1-14.

Kramer-Kile, M. L. (2012). Situating methodology within qualitative research. *Canadian Journal of Cardiovascular Nursing, 22*(4), 27-31.

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: Barriers, facilitators, and the way forward. *BMC Nursing, 20*. https://doi.org/doi.org/10.1186/s12912-021-00684-2

LeCompte, M. D., & Schensul, J. J. (2010). *Designing & conducting ethnographic research: An introduction* (2nd ed.). Rowman & Littlefield.

Leese, J., Li, L. C., Nimmon, L., Townsend, A. F., & Backman, C. L. (2021). Moving beyond "until saturation was reached": Critically examining how saturation is used and reported in qualitative research. *Arthritis Care & Research, 73*(9), 1225-1227.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. In Y. S. Lincoln & E. G. Guba (Eds.), *Naturalistic inquiry* (pp. 289-331). Sage. http://books.google.ca/books?id=2oA9aWlNeooC&printsec=frontcover&dq=lincoln+gub

a+1985+naturalistic+inquiry+credibility&hl=en&sa=X&ei=uyofU5_JKubg2QWRmIGYBA&ved=0CDYQ6AEwAA#v=onepage&q=lincoln%20guba%201985%20naturalistic%20inquiry%20credibility&f=false

Lipson, J. (1991). The use of self in ethnographic research. In J. M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 73-89). Sage.

Malinowski, B. (1922). *Argonauts of the western pacific*. Dutton.

Martina, D., Lin, C., Kristanti, M. S., Bramer, W. M., Mori, M., Korfage, I. J., van der Heide, A., van der Rijt, C. D., & Rietjens, J. A. C. (2021). Advance care planning in Asia: A systematic narrative review of healthcare professionals' knowledge, attitude, and experience. *Journal of the American Medical Directors Association, 22*(2). https://doi.org/doi.org/10.1016/j.jamda.2020.12.018

Maunder, R., Heeney, N., Strudwick, G., Shin, H., O'Neill, B., Young, N., Jeffs, L., Barrett, K., Bodmer, N., Born, K., Hopkins, J., Juni, P., Kerhun, A., Price, D., Razak, F., Muchquash, C., & Mah, L. (2021). Burnout in hospital-based healthcare workers during COVID-19. *Science Briefs of the Ontario COVID-19 Science Advisory Table*, *2*(46). https://doi.org/doi.org/10.47326/ ocsat.2021.02.46.1.0

McGillis Hall, L., & Visekruna, S. (2020). *Outlook on nursing: A snapshot from Canadian nurses on work environments pre-COVID-19*. Canadian Federation of Nurses Unions. https://nursesunions.ca/wp-content/uploads/2020/12/CFNU_outlook_ENfinal_web.pdf

McMahan, R. D., Tellez, I., & Sudore, R. L. (2020). Deconstructing the complexities of advance care planning outcomes: What do we know and where do we go? A scoping review. *Journal of the American Geriatrics Society, 00*(00), 1-11. https://doi.org/10.1111/jgs.16801

McMillan, K. (2016). Politics of change: The discourses that inform organizational change and their capacity to silence. *Nursing Inquiry, 23*(223-231).

McMillan, K. (2018). *A critical organizational analysis of frontline nurses' experience of rapid and continuous change in an acute health care organization* University of Ottawa].

Miedema, D. (2013). *Why Canada needs more palliative care*. I. o. M. a. F. Canada.

Miles, M. B., Huberman, M. A., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Sage.

Mohan, S., O. A., , O'Malley, J., Rudolph, M., Bynum, J., Murphy, M., & Barnato, A. E. (2020). A New Standard for Advance Care Planning (ACP) Conversations in the Hospital: Results from a Delphi Panel. *Journal of General Internal Medicine 36*(1), 69-76. https://doi.org/https://doi.org/10.1007/s11606-020-06150-0

Morse, J. M. (2018). Reframing rigor in qualitative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (5th ed., pp. 1373-1385). Sage.

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 2nd article.

Morse, J. M., & Field, P. (1995). *Qualitative research methods for health professionals*. Sage.

Müller, R., Cohen, C., Delmas, P., Pasquier, J., Baillif, M., & Butcher, C. O. (2021). Scope of nursing practice on a surgery ward: A time-motion study. *Journal of Nursing Management, 29*, 1785-1800.

Najafizada, M., Rahman, A., & Oxford, K. (2021). Analyzing models of patient-centered care in Canada through a scoping review and environmental scan. *Journal of Public Health: From Theory to Practice*. https://doi.org/doi.org/10.1007/s10389-021-01528-8

National Institute on Ageing. (2019). *Enabling the future provision of long-term care in Canada*. https://static1.squarespace.com/static/5c2fa7b03917eed9b5a436d8/t/5d9de15a38dca21e46009548/1570627931078/Enabling+the+Future+Provision+of+Long-Term+Care+in+Canada.pdf

Nicosia, F. M., Park, L. G., Gray, C. P., Yakir, M. J., & Hung, D. Y. (2018). Nurses' perspectives on lean redesigns to patient flow and inpatient discharge process efficiency. *Global Qualitative Nursing Research*, *5*, 1-10.

Oberle, K., & Hughes, D. (2001). Doctors' and nurses' perceptions of ethical problems in end-of-life decisions. *Journal of Advanced Nursing*, *33*(6), 707-715.

Ontario Health Coalition. (2016). *Hospital overload: Backgrounder on Ontario's Hospital Bed Shortage*. http://www.ontariohealthcoalition.ca/wp-content/uploads/backgrounder-on-hospital-bed-shortage.pdf

Ontario Ministry of Health and Long Term Care. (1990). *Public Hospitals Act*. https://www.ontario.ca/laws/statute/90p40

Papastavrou, E., Andreaou, P., & Vryonides, S. (2014). The hidden ethical element of nursing care rationing. *Nursing Ethics*, *21*(5), 583-593. https://doi.org/doi:10.1177/0969733013513210

Putman-Casdorph, H., Drenning, C., Richards, S., & Messenger, K. (2009). Advance directives: evaluation of nurses' knowledge, attitude, confidence, and experience. *Journal of Nursing Care Quality*, *24*(3), 250-256. https://doi.org/10.1097/NCQ.0b013e318194fd69

Rankin, J. (2003). "Patient satisfaction": Knowledge for ruling hospital reform - An institutional ethnography. *Nursing Inquiry*, *10*(1), 57-65.

Rankin, J. (2009). The nurse project: An analysis for nurses to take back our work. *Nursing Inquiry, 16*(4), 275-286.

Rankin, J., & Campbell, M. (2006). *Managing to nurse: Inside Canada's health care reform*. University of Toronto Press.

Rankin, J., & Campbell, M. (2009). Institutional ethnography (IE), nursing work and hospital reform: IE's cautionary analysis. *Forum: Qualitative Social Research, 10*(2), Article 8.

Rathert, C., Wyrwich, M. D., & Boren, S. A. (2012). Patient-centered care and outcomes: A systematic review of the literature. *Medical Care Research and Review, 70*(4), 351-379. https://doi.org/DOI: 10.1177/1077558712465774

Registered Nurses' Association of Ontario. (2021). *Work and wellbeing survey results*. https://rnao.ca/news/results-nursing-survey-point-alarming-exodus-profession-following-pandemic

Reitjens, J. A., Sudore, R. L., Connolly, M., van Delden, J. J., Drickamer, M. A., Droger, M., van der Heide, A., Heyland, D. K., Houttekier, D., Janssen, D. J., Orsi, L., Payne, S., Seymour, J., Jox, R. J., & Kofage, I. J. (2017). Definition and recommendations for advance care planning: An international consensus supported by the European association for palliative care. *Lancet Oncology, 18*(9), e543-e551. https://doi.org/10.1016/s1470-2045(17)30582-x

Richards, L., & Morse, J. M. (2013). *README FIRST for a user's guide to qualitative methods* (3rd ed.). Sage.

Rietze, L., Heale, R., Roles, S., & Hill, L. (2018). Identifying the factors associated with Canadian registered nurses' engagement in advance care planning. *Journal of Hospice & Palliative Nursing, 20*(3), 230-236.

Rietze, L., & Stajduhar, K. (2015). Registered nurses' involvement in advance care planning: An integrative review. *International Journal of Palliative Nursing, 21*(10), 495-503.

Roper, J. M., & Shapira, J. (2000a). Ethnography as method. In J. M. Roper & J. Shapira (Eds.), *Ethnography in nursing research* (pp. 11-28). Sage.

Roper, J. M., & Shapira, J. (2000b). *Ethnography in nursing research*. Sage.

Rudge, T. (2013). Desiring productivity: Nary a wasted moment, never a missed step! *Nursing Philosophy, 14*, 201-211. https://doi.org/doi: 10.1111/nup.12019

Rudolph, N. (2017). Hierarchies of knowledge, incommensurabilities and silences in South African ECD policy: Whose knowledge counts? *Journal of Pedagogy, 8*(1), 77-98. https://doi.org/10.1515/jped-2017-0004

Saifan, A., Devadas, B., Daradkeh, F., Abdel-Fattah, H., Alijabery, M., & Michael, L. M. (2021). Solutions to bridge the theory-practice gap in nursing education in the UAE: A qualitative study. *BMC Medical Education, 21*. https://doi.org/doi.org/10.1186/s12909-021-02919-x

Sandelowski, M. (1995). Sample size in qualitative research *Research in Nursing & Health, 18*, 179-183. https://doi.org/doi:10.1002/ (ISSN)1098-240X

Schenk, E., Schleyer, R., Jones, C. R., Fincham, S., Daratha, K. B., & Monsen, K. A. (2017). Time motion analysis of nurses work in ICU, telemetry and medical-surgical units. *Journal of Nursing Management, 25*, 640-646. https://doi.org/DOI: 10.1111/jonm.12502

Schluter, J., Winch, S., Holzhauser, K., & Henderson, A. (2008). Nurses' moral sensitivity and hospital ethical climate. *Nursing Ethics, 15*(3), 304-321.

Schulman-Green, D., McCorkle, R., Cherlin, E., Johnson-Hurzeler, R., & Bradley, E. H. (2005). Nurses' communication about prognosis and implications for hospice referral: A study of

nurses caring for terminally ill hospitalized patients. *American Journal of Critical Care, 14*(1), 64-70.

Scott, T., Mannion, R., Marshall, M., & Davies, H. (2003). Does organizational culture influence health care performance? A review of the evidence. *Journal of Health Services Research and Policy, 8*, 105-117.

Seal, M. (2007). Patient advocacy and advance care planning in the acute hospital setting. *Australian Journal of Advanced Nursing, 24*(4), 29-36. http://search.ebscohost.com/login.aspx?direct=true&db=cin20&AN=2009636353&site=ehost-live

Selberg, R. (2013). Nursing in times of neoliberal change: An ethnographic study of nurses' experiences of work intensification. *Nordic Journal of Working Life Studies, 3*(2), 9-35.

Shah, M., Gandrakota, N., Cimiotti, J., Ghose, N., Moore, M., & Ali, M. (2021). Prevalence of and factors associated with nurse burnout in the US. *JAMA, 4*(2). https://doi.org/doi.org/10.1001/jamanetworkopen.2020.36469

Shamian, J. (2016). Nurses care improve the strength and resilience of healthcare systems. *British Journal of Nursing, 25*(9), 503.

Shanley, C., & Wall, S. (2004). Promoting patient autonomy and communication through advance care planning: A challenge for nurses in Australia. *Australian Journal of Advanced Nursing, 21*(1), 32-38.

Shannon, V., & French, S. (2005). The impact of the re-engineered world of health-care in Canada on nursing and patient outcomes. *Nursing Inquiry, 12*(3), 231-239. http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009027343&login.asp&site=ehost-live&scope=site

Shorr, A. F., Niven, A. S., Katz, D. E., Parker, J. M., & Eliasson, A. H. (2000). Regulatory and educational initiatives fail to promote discussions regarding end-of-life care. *Journal of Pain & Symptom Management*, *19*(3), 168-172.

Smith, D. E. (1987). Institutional ethnography: A feminist research strategy. In D. E. Smith (Ed.), *The everyday world as problematic: A feminist sociology* (pp. 151-179). Toronto University Press.

Spence Laschinger, H. K., Sabiston, J. A., Finegan, J., & Shamian, J. (2001, 2001 Jan-Feb). Voices from the trenches: nurses' experiences of hospital restructuring in Ontario. *Canadian Journal of Nursing Leadership*, *14*(1), 6-13. http://ezproxy.library.uvic.ca/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2001073369&login.asp&site=ehost-live&scope=site

Spradley, J. (1979). *The ethnographic interview*. Holt, Rinehart & Winston.

Spradley, J. (1980). *Participant observation*. Holt, Rinehart & Winston.

Starr, L. T., Ulrich, C. M., Corey, K. L., & Meghani, S. H. (2019). Associations among end-of-life discussions, health-care utilization, and costs in persons with advanced cancer: A systematic review. *American Journal of Hospice & Palliative Medicine*, *36*(10), 913-926.

Statistics Canada. (2019a). *Changes in life expectancy by selected causes of death, 2017*. https://www150.statcan.gc.ca/n1/daily-quotidien/190530/dq190530d-eng.htm

Statistics Canada. (2019b). *Population projections for Canada (2018 to 2068), provinces and territories (2018 to 2043)*. https://www150.statcan.gc.ca/n1/pub/91-520-x/91-520-x2019001-eng.htm

Statistics Canada. (2020). *Demographic estimates by age and sex, provinces and territories*. https://www150.statcan.gc.ca/n1/pub/71-607-x/71-607-x2020018-eng.htm

Stewart, F., Goddard, C., Schiff, R., & Hall, S. (2011, May). Advanced care planning in care homes for older people: a qualitative study of the views of care staff and families [Research Support, Non-U.S. Gov't]. *Age Ageing, 40*(3), 330-335. https://doi.org/10.1093/ageing/afr006

Strouse, S. M., Nickerson, C. J., & McCloskey, E. M. (2018). We don't miter the sheets on the bed: Understanding the preceptor role in the enculturation of nursing students. *Nurse Education in Practice, 32*, 21-27.

Sudore, L., H. D., , You, J. J., Hanson, L. C., Meier, D. E., Pantilat, S. Z., Matlock, D. D., Rietjens, J. A. C., Korfage, I. J., Ritchie, C. S., Kutner, J. S., Teno, J. M., Thomas, J., McMahan, R. D., & Heyland, D. K. (2017). Defining Advance Care Planning for Adults: A Consensus Definition From a Multidisciplinary Delphi Panel. *Journal of Pain and Symptom Management, 53*(5), 821-832. https://doi.org/https://doi.org/10.1016/j.jpainsymman.2016.12.331

Sudore, R. L., & Fried, T. R. (2010). Redefining the "planning" in advance care planning: Preparing for end-of-life decision making. *Annals of Internal Medicine, 153*(4), 256-262.

Sutherland, J. M. (2011). *Hospital repayment mechanisms: An overview and options for Canada*. https://www.chsrf.ca

Teno, J. M., Fisher, E., Hamel, M. B., Wu, A. W., Murphy, D. J., Wenger, N. S., Lynn, J., & Harrell, F. E. J. (2000). Decision-making and outcomes of prolonged ICU stays in seriously ill patients. *Journal of the American Geriatrics Society, 48*(5), S70-74.

Thompson, G., McClement, S., & Daeninck, P. (2006). Nurses' perceptions of quality end-of-life care on acute medical wards. *Journal of Advanced Nursing, 53*(2), 169-177. https://doi.org/10.1111/j.1365-2648.2006.03712.x

Thorne, S. (2020). The great saturation debate: What the "S Word" means and doesn't mean in qualitative research reporting. *Canadian Journal of Nursing Research, 52*(1), 3-5.

Thorne, S. (2021). Regaining our professional vision. *Nursing Leadership, 34*, 151-156.

Thorne, S., & Stajduhar, K. (2017). Rebuilding the roots of patient-centred care. *Nursing Leadership, 30*(1), 23-29.

Van Osch, M., Scarborough, K., Crowe, S., Wolff, A. C., & Reimer Kirkham, S. (2018). Understanding the factors which promote registered nurses' intent to stay in emergency and critical care areas. *Journal of Clinical Nursing, 27*(5-6), 1209-1215.

Vanderhaeghen, B., Bossuyt, I., Opdebeeck, S., Menten, J., & Rober, P. (2018). Toward hospital implementation of advance care planning: Should hospital professionals be involved? *Qualitative Health Research, 28*(3), 456-465.

Verrall, C., Abery, E., Harvey, C., Henderson, J., Willis, E., Hamilton, P., Toffoli, L., & Blackman, I. (2015). Nurses and midwives perceptions of missed nursing care - A South Australian study. *Collegian, 22*(4), 413-420.

Wadams, M. (2018). Qualitative research in correctional settings: Researcher bias, western ideological influences, and social justice. *Journal of Forensic Nursing, 14*(2), 72-79. https://doi.org/10.1097/JFN.0000000000000199

Walker, H., Anderson, M., Farahati, F., Howell, D., Librach, S. L., Husain, A., Sussman, J., Viola, R., Sutradhar, R., & Barbera, L. (2011). Resource use and costs of end-of-life/palliative care: Ontario adult cancer patients dying during 2002 and 2003. *Journal of Palliative Care, 27*(2), 79-88.

Whitehead, F., E., , Johnstone-Petty, M., Kates, J., Tay, D. L., DeSanto, K., & Fink, R. M. (2021). A scoping review of nurse-led advance care planning. *Nursing Outlook*. https://doi.org/https://doi.org/10.1016/j.outlook.2021.08.002

Willard, C., & Luker, K. (2006). Challenges to end of life care in the acute hospital setting. *Palliative Medicine, 20*, 611-615.

Willgens, A. M., Cooper, R., Jadotte, D., Lilyea, B., Langtiw, C., & Obenchain-Leeson, A. (2016). How to enhance qualitative research appraisal: Development of the methodological congruence instrument. *The Qualitative Report, 21*(12), 2380-2395, Article 2.

Wolcott, H. F. (1990). *Writing up qualitative research*. Sage.

Wolf, M. (1992). *The thrice told tale*. University of California Press.

Wolf, Z. (2012). Ethnography: The method. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective*. Jones & Bartlett.

Wong, H., Wang, J., Grinman, M., & Wu, R. (2016). Goals of care discussions amongst hospitalized long-term care residents: Predictors and associated outcomes of care. *Journal of Hospital Medicine, 11*(12), 824-831.

Appendix A: Recruitment Poster

New Research Study: **Advance care planning between registered nurses and their acute care patients**

Principal Investigator:
Lori Rietze, RN, PhD candidate
School of Nursing
University of Victoria

What is the study about?

Hospitals are the most common place of death for Canadians. Yet, we do not know the extent to which registered nurses are able to engage their hospitalized patients living with chronic illnesses in conversations about end of life decision making. This study aims to better understand the types of conversations that occur between registered nurses and their seriously ill patients in hospital in order to better support patients.

What would be asked of you?

You will be invited to complete a five minute demographic survey and participate in an interview which will take approximately 1h of your time at a location of your choice. If you are a member of a multidisciplinary health care team in your organization, you may also be approached for consent to allow a researcher to observe team interactions.

Who may be included?

Part-time or full-time registered nurses, unit managers, administrative directors, clinical leads.

Got questions or interested in participating?

Lori Rietze, PhD nursing student, University of Victoria; Faculty, Laurentian University,

This research has been approved by the University of Victoria and Laurentian University Research Ethics Boards (Certificate numbers 19-0420 and 6020475).

University of Victoria

LaurentianUniversity UniversitéLaurentienne

Appendix B: Email Invitation for Registered Nurses

Advance Care Planning between Registered Nurses and Their Acute Care Patients

I'm writing to invite you to participate in a study that will begin early this winter in your health care setting. The study is entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients.* This study is being conducted by Lori Rietze, RN, MSc, PhD (c), graduate student in the School of Nursing at the University of Victoria and faculty member at Laurentian University.

As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in nursing. The study is also being conducted under the supervision of Dr. Kelli Stajduhar, School of Nursing, University of Victoria.

Hospitals are still the most common place of death for Canadians. Yet, we do not know the extent to which registered nurses are able to engage their hospitalized patients living with chronic illnesses in conversations about end of life decision making. This study aims to better understand the types of conversations that occur between registered nurses and their patients in hospital with the end goal of better supporting patients.

I am looking to interview registered nurses working on your unit to learn about conversations that you have had with your patients who are close to the end of life.
If you are interested in learning more about how to participate in this study, please email me at XX.

Thank you in advance,

Lori Rietze, RN, PhD candidate

PhD Student
University of Victoria

Assistant Professor
Laurentian University

University of Victoria
LaurentianUniversity UniversitéLaurentienne
Health Sciences North Horizon Santé-Nord
North Bay Regional Health Centre Centre régional de santé de North Bay

Appendix C: Email Invitation for Administrators

Advance Care Planning between Registered Nurses and Their Acute Care Patients

I'm writing to invite you to participate in a study that will begin early this winter in your health care setting. The study is entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients.* This study is being conducted by Lori Rietze, RN, MSc, PhD candidate, graduate student in the School of Nursing at the University of Victoria and faculty member at Laurentian University.

As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in nursing. The study is also being conducted under the supervision of Dr. Kelli Stajduhar, School of Nursing, University of Victoria.

Hospitals are still the most common place of death for Canadians. Yet, we do not know the extent to which registered nurses are able to engage their hospitalized patients living with chronic illnesses in conversations about end of life decision making. This study aims to better understand the types of conversations that occur with patients in hospital settings and the ways in which organizations support this work. The end goal of this research is to better support patients. I am looking to interview administrators of health care organizations to learn about the organizational influences on nurses' conversations with patients who are close to the end of life.

If you are interested in learning more about how to participate in this study, please email me at XX or XX.

Thank you in advance,

Lori Rietze, RN, PhD candidate

PhD Student
University of Victoria

Assistant Professor
Laurentian University

University of Victoria

LaurentianUniversity
UniversitéLaurentienne

Appendix D: Demographic Data Collection Form for Registered Nurses

Demographic Form – Registered Nurses

Thank you for agreeing to participate in the study entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients*. Please complete the following demographic questionnaire that will be used to describe the type of people who participated in the study.

What's your sex? ☐ MALE ☐ FEMALE

What's your year of birth? _____

What's the highest educational level you have completed?

☐ RN DIPLOMA ☐ BScN DEGREE ☐ GRADUATE

Have you taken additional courses in palliative care beyond your formal nursing courses?

☐ YES ☐ NO

What year did you graduate from nursing school? _____

Have you ever engaged in advance care planning in your personal life?

☐ YES ☐ NO

How long have you worked on this unit?

☐ 0-3 years ☐ 4-7 years ☐ 8-11 years ☐ 12+ years

On average, how many patients do you care for each week who are at the end of life?

☐ 0 ☐ 1-2 ☐ 3-4 ☐ 4+

Which shifts do you usually work on this unit?

☐ days ☐ evenings ☐ nights ☐ mixture

Unique Identifier Code: _____

Appendix E: Demographic Data Collection Form for Administrators

Demographic Form – Administrators

Thank you for agreeing to participate in the study entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients*. Please complete the following demographic questionnaire that will be used to describe the type of people who participated in the study.

What's your sex? ☐ MALE ☐ FEMALE

What's your year of birth? _____

What's the highest educational level you have completed?

☐ DIPLOMA ☐ DEGREE ☐ GRADUATE

In which discipline was your formal training? _____

How long have you been an administrator for this unit?

☐ 0-3 years ☐ 4-7 years ☐ 8-11 years ☐ 12+ years

How long have you been working for this organization? _____months/years

---

Unique Identifier Code: _____

Appendix F: Consent Form for Registered Nurses

Advance Care Planning between Registered Nurses and Their Acute Care Patients

You are invited to participate in a study entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients* that is being conducted by Lori Rietze, RN, MSc, PhD candidate, graduate student in the School of Nursing at the University of Victoria and faculty member at Laurentian University. You may contact her at XX /toll free at XX if you have further questions.

As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in nursing. It is being conducted under the supervision of Dr. Kelli Stajduhar. You may contact my supervisor at XX.

Purpose and Objectives

Since hospital settings continue to be the most common place of death for Canadians, advance care planning in hospitals has been used to enhance patient-centered care and promote patient decisions at the end of life. But, there has been little research to understand how nurses are managing end of life communication such as advance care planning while maintaining their current workload. The purpose of this study is to better understand the types of conversations that occur between registered nurses and their seriously ill patients in hospital and how organizations are influencing this work.

Importance of this Research

This research will identify the circumstances in which nurses and their seriously ill patients engage in aspects of advance care planning and the ways in which organizations are supporting this work. The end goal of this research is to better support patients.

Participants Selection

You are being asked to participate in this study because you are a registered nurse who works on a unit in which this study will be conducted.

What is involved

If you consent to voluntarily participate in this research, your participation will include a five minute demographic survey and a recorded interview which will take approximately 1 hour in a location at your convenience. You will also be invited to be observed at multidisciplinary meetings held at your health care setting during your regular working hours.

Risks

Research participants may experience feelings of distress or emotional discomfort during the interview.

Benefits

The potential benefits of your participation in this research may include satisfaction from sharing your practice experiences and a sense of accomplishment in your contribution to the advancement of human knowledge. It is expected that you may also benefit from participation in this study if organizational leads become more aware of the supports required for nurses to engage in advance care planning while maintaining their current workload.

Voluntary Participation

Your participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. However, since your interview data will be anonymous, your data cannot be deleted if you choose to withdraw after the interview. Your choice to accept or decline the invitation to participate in all or parts of this study will not impact your employment or opportunities within your health care setting or associated universities.

Anonymity

After completing interviews, each participant will be assigned a numeric code instead of their name. During observation, no names will be collected from members at the meeting. This will ensure anonymity of your data in this study as you will not be identifiable in the study data.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by securely storing the data and electronic files. Interview transcriptions and observational notes will be stored on Canadian servers that are encrypted and password protected. Once encrypted interview recordings are transcribed, the original recording will be deleted. Hard copies of consent forms and demographic surveys will be securely locked in a cabinet in the locked office of the primary researcher at Laurentian University. Once the demographic data is collated into a table, hard copies of the demographic forms will be shredded in a portable shredder and disposed. Tabular data will be consolidated and will not contain identifiable information. The tabular data will be stored in a computer file that will be saved on an encrypted, password protected cloud. Results will be published in academic journals and/or presented at conferences but participant identity or the name of the participating units and organizations will not be disclosed.

Dissemination of Results

The results of this study will be shared with participants in an elective 1-page summary and findings will be disseminated to the academic community by way of research publications, dissertation publication, and presentations at conferences.

Disposal of Data

Paper data such as demographic forms and consent forms will be disposed of by shredding in a portable shredder and recycled. Electronic data such as interview recordings will be deleted and erased from the recording device. However, non-identifiable collated data such tabular, field notes, and anonymized transcript data will be retained for future graduate students and further secondary analysis by Lori Rietze. Research ethics approval will be sought before any secondary analysis is done with this data. All non-identifiable stored data will remain housed in encrypted password protected Canadian servers maintained by Laurentian University.

Contacts

Individuals that may be contacted regarding this study include Lori Rietze, graduate student in the School of Nursing at the University of Victoria and faculty member at Laurentian University, or Dr. Kelli Stajduhar, graduate supervisor.
In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria or the Research Ethics Officer at Laurentian University.

Consent to Email Summary of Results

I consent to be sent a 1-page summary of the study findings by email:

_____(Participant Email address)

Your signature below indicates that:

a. All sections of this consent form have been explained to your satisfaction
b. You understand the requirements, risks, potential and responsibilities of participating in the research project
c. You understand how your information will be accessed, collected and used
d. You understand that the aggregate data may be analyzed in the future
e. All of your questions have been fully answered by the researchers
f. You consent to participate in the study
g. You consent to the use of an encrypted recording device during the interview

_____	_____	_____
Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

_____

_____ Unique Identifier Code: _____

Appendix G: Consent form for Administrators

Advance Care Planning between Registered Nurses and Their Acute Care Patients

You are invited to participate in a study entitled *Advance Care Planning between Registered Nurses and Their Acute Care Patients* that is being conducted by Lori Rietze, RN, MSc, PhD candidate, graduate student in the School of Nursing at the University of Victoria and faculty member at Laurentian University. You may contact her at XX if you have further questions. As a graduate student, I am required to conduct research as part of the requirements for a PhD degree in nursing. It is being conducted under the supervision of Dr. Kelli Stajduhar. You may contact my supervisor at XX.

Purpose and Objectives

Since hospital settings continue to be the most common place of death for Canadians, advance care planning in hospitals has been used to enhance patient-centered care and promote patient decisions at the end of life. But, there has been little research to understand how nurses are managing end of life communication such as advance care planning while maintaining their current workload. The purpose of this study is to better understand the types of conversations that occur between registered nurses and their seriously ill patients in hospital and how organizations are influencing this work. The end goal of this research is to better support patients.

Importance of this Research

This research will identify the circumstances in which nurses and their seriously ill patients engage in aspects of advance care planning and the ways in which organizations are supporting this work.

Participants Selection

You are being asked to participate in this study because you are an administrator of a unit on which this study is being conducted.

What is involved

If you consent to voluntarily participate in this research, your participation will include a five minute demographic survey and a recorded interview which will take approximately 1 hour in a location at your convenience. You will also be invited to be observed at multidisciplinary meetings held at your health care setting during your regular working hours.

Risks

Research participants may experience feelings of distress or emotional discomfort during the interview.

Benefits

The potential benefits of your participation in this research may include satisfaction from sharing your practice experiences and a sense of accomplishment in your contribution to the advancement of human knowledge. It is expected that you may also benefit from participation in this study if organizational leads become more aware of the supports required for nurses to engage in advance care planning while maintaining their current workload.

Voluntary Participation

Your participation in this research must be completely voluntary. If you decide to participate, you may withdraw at any time without any consequences or any explanation. However, since your interview data will be anonymous, your data cannot be deleted if you choose to withdraw after the interview. Your choice to accept or decline the invitation to participate in all or parts of this study will not impact your employment or opportunities within your health care setting or associated universities.

Anonymity

After completing interviews, each participant will be assigned a numeric code instead of their name. During observation, no names will be collected from members at the meeting. This will ensure anonymity of your data in this study as you will not be identifiable in the study data.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by securely storing the data and electronic files. Interview transcriptions and observational notes will be stored on Canadian servers that are encrypted and password protected. Once encrypted interview recordings are transcribed, the original recording will be deleted. Hard copies of consent forms and demographic surveys will be securely locked in a cabinet in the locked office of the primary researcher at Laurentian University. Once the demographic data is collated into a table, hard copies of the demographic forms will be shredded in a portable shredder and disposed. Tabular data will be consolidated and will not contain identifiable information. The tabular data will be stored in a computer file that will be saved on an encrypted, password protected cloud. Results will be published in academic journals and/or presented at conferences but participant identity or the name of the participating units and organizations will not be disclosed.

Dissemination of Results

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Disposal of Data

Paper data such as demographic forms and consent forms will be disposed of by shredding in a portable shredder and recycled. Electronic data such as interview recordings will be deleted and erased from the recording device. However, non-identifiable collated data such tabular, field notes, and anonymized transcript data will be retained for future graduate students and further secondary analysis by Lori Rietze. Research ethics approval will be sought before any secondary analysis is done with this data. All non-identifiable stored data will remain housed in encrypted password protected Canadian servers maintained by Laurentian University.

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Consent to Receive Summary of Results

I consent to be sent a 1-page summary of the study findings by email

_____(Participant Email address)

Your signature below indicates that:

a. All sections of this Consent form have been explained to your satisfaction
b. You understand the requirements, risks, potential and responsibilities of participating in the research project
c. You understand how your information will be accessed, collected and used
d. You understand that the aggregate data may be analyzed in the future
e. All of your questions have been fully answered by the researchers
f. You consent to participate in the study
g. You consent to the use of an encrypted recording device during the interview

_____	_____	_____
Name of Participant	*Signature*	*Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

_____

_____ Unique Identifier Code: _____

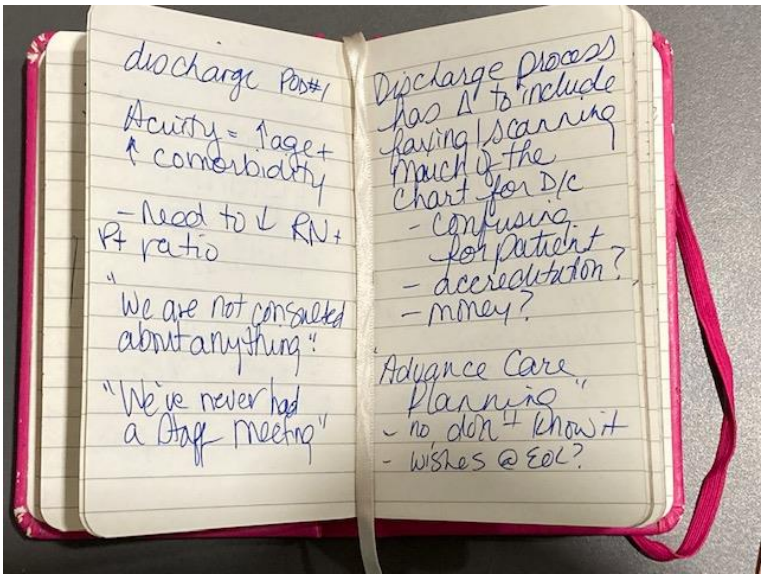
Appendix H: Observation Guide of a Meeting

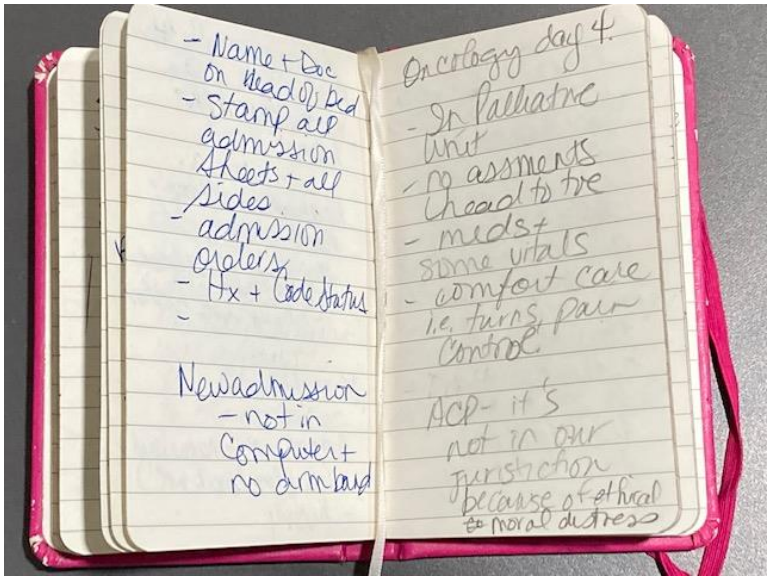
The main goal of these observations is to document is to determine if ACP is coming up in the conversations among the health care team. In doing so, I will be looking for what kind of planning for patients is generally going on, who does it, when, why and how. I will be also interested in how the ACP information is used at the team meeting level to plan for patient care.
Description of the meeting: • *Describe the physical space of the meeting* • *Who is present, how are they seated, how is the meeting organized, who is chairing the meeting, what is the purpose of the meeting, length of the meeting, where it is held.* • *Describe how patient wishes related to their care is introduced, when, by who, and who is interested in it. Where is it recorded?* • *Describe any non-verbal communication patterns* • *Describe how clinical decisions about advance care planning are made by registered nurses?* • *How much are nurses directed by organizations to engage patients in advance care planning? How does this happen?* • *Power usage in the room – where do disciplines usually sit? How is body language used, tone and volume of voice, amount of time given for speaking.*

Appendix I: Fieldwork Calendar

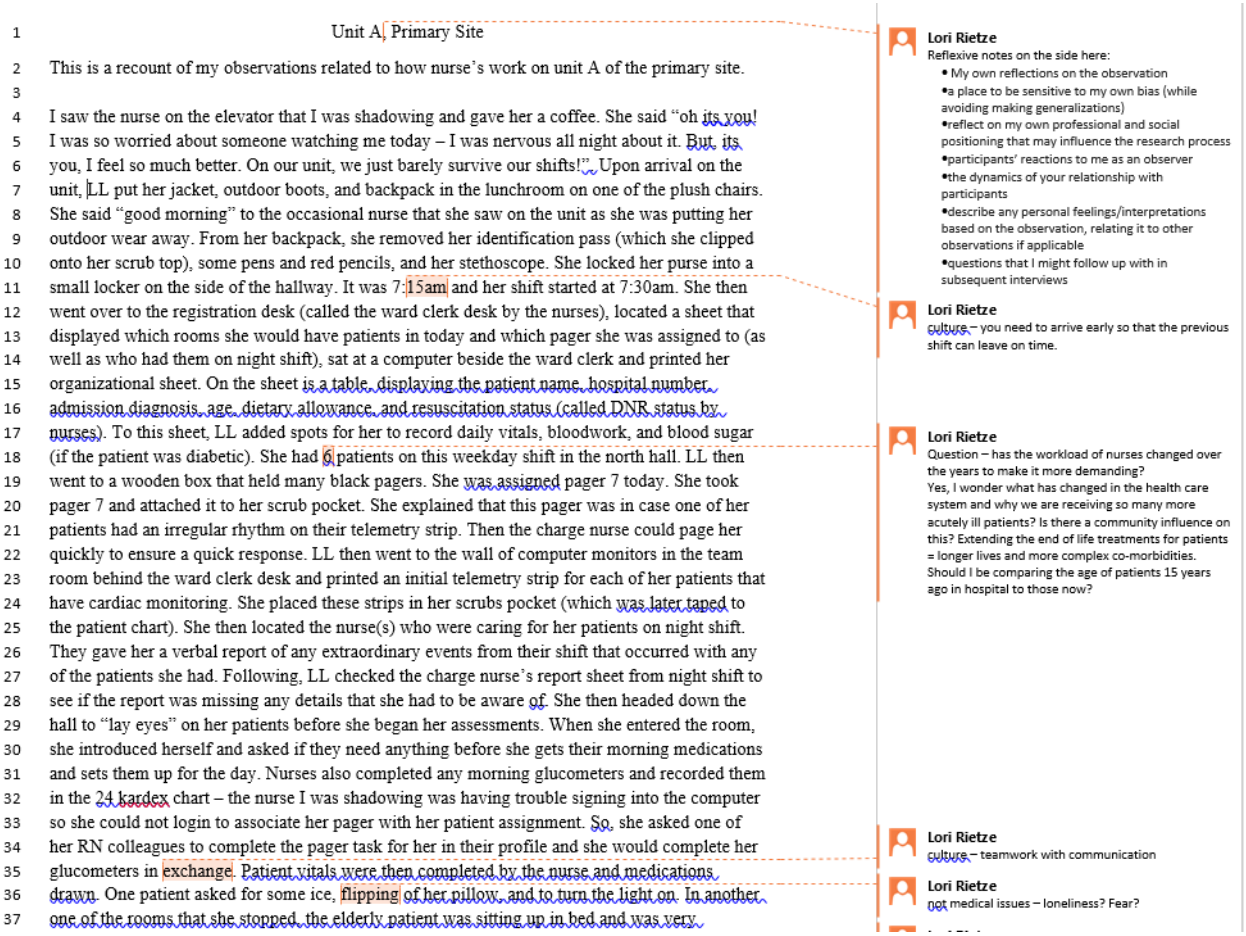
PHASE	DATE	ACTIVITY
	November 4, 2019	REB approval from UVic
Preparatory Phase of Fieldwork	November 6, 2019	REB approval from LU and primary site
	December 20, 2019	REB approval from secondary site
	January 2020	Met with organizational gatekeepers and managers
First Phase of Fieldwork	January 2020-June 2020	Observation on unit A (12h) Observation on unit B (4h) Interviews with 5 administrators Interviews with 3 registered nurses Observation of a Palliative Care Committee Meeting Data Analysis: Development of initial big buckets, Independent Peer Review of Data Analysis, Revisions to first level thematic codes
COVID DELAY	June-August 2020	COVID-19 Pandemic in hospital settings closed acute care settings to students and researchers
Second Phase of Fieldwork	August 2020-January 2021	Observation on unit A (8h) Observation on unit B (16h) Observation on unit C (10h) Interviews with 4 administrators Interviews with 11 registered nurses Data analysis Revisions to thematic codes
COVID DELAY	January 2021-August 2021	COVID-19 Pandemic in hospital settings closed acute care settings to students and researchers
TOTAL OBSERVATIONAL FIELDWORK HOURS: 50 TOTAL INTERVIEWS: 23		
Analysis Writing	September 2021-April 2022	Continued analysis of data and revisions to thematic codes Dissertation writing
Disseminate Findings	November 2022	One page summary of the study findings will be emailed to participants who provided their email address on the consent form Manuscript preparation for publication

Appendix J: Inscription Notes





Appendix K: Transcription Notes



Unit A, Primary Site

This is a recount of my observations related to how nurse's work on unit A of the primary site.

I saw the nurse on the elevator that I was shadowing and gave her a coffee. She said "oh its you! I was so worried about someone watching me today – I was nervous all night about it. But, its you, I feel so much better. On our unit, we just barely survive our shifts!". Upon arrival on the unit, LL put her jacket, outdoor boots, and backpack in the lunchroom on one of the plush chairs. She said "good morning" to the occasional nurse that she saw on the unit as she was putting her outdoor wear away. From her backpack, she removed her identification pass (which she clipped onto her scrub top), some pens and red pencils, and her stethoscope. She locked her purse into a small locker on the side of the hallway. It was 7:15am and her shift started at 7:30am. She then went over to the registration desk (called the ward clerk desk by the nurses), located a sheet that displayed which rooms she would have patients in today and which pager she was assigned to (as well as who had them on night shift), sat at a computer beside the ward clerk and printed her organizational sheet. On the sheet is a table, displaying the patient name, hospital number, admission diagnosis, age, dietary allowance, and resuscitation status (called DNR status by nurses). To this sheet, LL added spots for her to record daily vitals, bloodwork, and blood sugar (if the patient was diabetic). She had 6 patients on this weekday shift in the north hall. LL then went to a wooden box that held many black pagers. She was assigned pager 7 today. She took pager 7 and attached it to her scrub pocket. She explained that this pager was in case one of her patients had an irregular rhythm on their telemetry strip. Then the charge nurse could page her quickly to ensure a quick response. LL then went to the wall of computer monitors in the team room behind the ward clerk desk and printed an initial telemetry strip for each of her patients that have cardiac monitoring. She placed these strips in her scrubs pocket (which was later taped to the patient chart). She then located the nurse(s) who were caring for her patients on night shift. They gave her a verbal report of any extraordinary events from their shift that occurred with any of the patients she had. Following, LL checked the charge nurse's report sheet from night shift to see if the report was missing any details that she had to be aware of. She then headed down the hall to "lay eyes" on her patients before she began her assessments. When she entered the room, she introduced herself and asked if they need anything before she gets their morning medications and sets them up for the day. Nurses also completed any morning glucometers and recorded them in the 24 kardex chart – the nurse I was shadowing was having trouble signing into the computer so she could not login to associate her pager with her patient assignment. So, she asked one of her RN colleagues to complete the pager task for her in their profile and she would complete her glucometers in exchange. Patient vitals were then completed by the nurse and medications drawn. One patient asked for some ice, flipping of her pillow, and to turn the light on. In another one of the rooms that she stopped, the elderly patient was sitting up in bed and was very

Lori Rietze
Reflexive notes on the side here:
- My own reflections on the observation
- a place to be sensitive to my own bias (while avoiding making generalizations)
- reflect on my own professional and social positioning that may influence the research process
- participants' reactions to me as an observer
- the dynamics of your relationship with participants
- describe any personal feelings/interpretations based on the observation, relating it to other observations if applicable
- questions that I might follow up with in subsequent interviews

Lori Rietze
culture – you need to arrive early so that the previous shift can leave on time.

Lori Rietze
Question – has the workload of nurses changed over the years to make it more demanding?
Yes, I wonder what has changed in the health care system and why we are receiving so many more acutely ill patients? Is there a community influence on this? Extending the end of life treatments for patients = longer lives and more complex co-morbidities. Should I be comparing the age of patients 15 years ago in hospital to those now?

Lori Rietze
culture – teamwork with communication

Lori Rietze
not medical issues – loneliness? Fear?

Appendix L: Descriptive Field Notes and Memos

Code number: P2
Observation type: Interview, administrator
January 31, 2020 @ 10:30am Unit C

***Memoing - Situating Myself**: I was nervous to meet with this participant because the site as a whole has not been as engaged in the study as I expected since they felt they did not do ACP on any of their units. Therefore, they assumed that an aspect of the study was to evaluate the extent to which they were caring for patients with quality. With this in mind, I chose to introduce the study as a dual pronged interest. First, was to understand ACP and the extent to which nurses felt that they were able to engage in this work, and the other part of the study was to get a sense of how nurses are managing their workload on this unit in this acute care setting. How are nurses prioritizing care? What are the factors influencing this work? Knowing that I was interested in learning about the culture on the unit and the nurses' processes in deciding their daily work with patients, things became easier to talk with the administrator. She relaxed. I then related that there is an interview aspect and there is an observation aspect to this study since many nurses may know why they practice in certain ways and others may not recognize why their routine is the way it is. This allowed me to set the understanding that I needed to recruit nurses but also administrators for the interviews but that observation was also a part of the study. We began talking about how many hours I would need to observe. I clarified that it would not be in patient rooms and I would not slow the nurses down in their routine with questions. The administrator said she would help me to recruit the nurses and administrators on the unit. I was so happy and relieved.*

Descriptive Field Notes	***Memoing - Analytic Reflective Field Notes***
The setting of the interview was in her closed office. We sat at a desk that was covered with papers. The room was quiet and private. My relationship with this administrator to this point was very uncertain since I had never met her before and she was only partially engaged in the email conversations about the study to this point. When I met her in her office for the interview, she was engaging, interested, charismatic, and welcoming. There were no distractions during the interview. I was careful to mimic her casual nature with the way that I sat, when I leaned forward, and when I spoke. I was intentionally non-judgmental about their lack of engagement in ACP on the unit or in the organization. Instead of focusing only on	*During this interview, I was shocked to hear that aside from identifying the SDM on admission to the acute care setting, there have been and still are no discussions with patients about ACP. Clearly, the administration on this unit is pre-contemplative about their role in ACP as health care providers. I wonder in these cases, other than asking why this is the case, should I be ready with some questions related to how the organization influences nurses' care in other topics (EMR, new medication carts, etc.)? This might help me to understand the context better? In this interview, such a scenario occurred – less of a focus on ACP practices (since she stated that there is none and there is no directive to doing so) and more on organizational influence.* *I am also seeing that there is very little discussion in these interviews about health care committee meetings that I might observe. Granted, in this interview, the participant stated that the Palliative Care Committee has a role in this setting related to the care of patients at the EOL. I already have permission from this committee to observe at their next meeting in March. So far though, there are fewer*

why this was, I was able to adjust the conversation to more heavily understanding how nurses decide what to prioritize in their care with patients on a daily basis and how innovations that are driven from the organization are diffused onto the unit and into routine care.	*opportunities to observe committees with health care providers than I would have expected. During my observation of a nurse x 16h (4 shifts x 4h each), I will attempt to observe during different shifts so that I can watch and listen to morning huddles and evening reports.*

Appendix M: Semi-Structured Interview Guide

Let me start by thanking you for agreeing to participate in this interview, your time is very valuable.
INTRO SELF - My name is Lori Rietze and I am a PhD student and a nurse at Laurentian University.
STUDY FOCUS - *I am interested in learning more about the types of conversations held between nurses and patients with serious life-limiting illnesses.* In this study, I am trying to understand the factors that makes it easy and hard for you to engage hospitalized patients in conversations about their values and wishes at the EOL. Ultimately, I am hoping that the study findings help to support patients in acute care.
CONSENT FORM, LOI - I will be **audio-recording** the interview to ensure that I completely and accurately capture your views, and to maximize the quality of the analysis. Also, I have a **note pad** here with me so that I can write down points that I'd like to remember. Is that ok?
The interview will take approximately 60 minutes, however, this may vary depending on your time and interest. How long do you have in your schedule for the interview?
DEMOGRAPHIC SURVEY – I have a demographic survey, can we complete this now?

Do you have any questions or concerns before we start?
May I turn on the recorder now?

In general, can you tell me about your experience caring for patients with serious illness on your unit?

Sub-questions:

1. What are things like on your unit?
2. Can you tell me about the kinds of patients you care for on your unit?
3. What does a typical shift look like?
4. What is it like being a nurse on your unit?
5. I am hearing that some of the paperwork completed by nurses in your setting such as admission, assessment, and discharge forms have become more complex. Can you talk to me about this?

Can you talk about how advance care planning with the patient is viewed by nurses within this unit?

Sub-questions:

1. What do you generally understand advance care planning to be?
2. What is the history of ACP on your unit?
3. Why did this happen/stop?
4. What is the current state on the unit in relation to ACP?
5. What is the role of the nurse when patients are declining?
6. Can you talk about why only some nurses do ACP but most nurses engage in DNR conversations with patients?

7. Some nurses talk about having to shift gears from specialty patients to medical patients on your unit. How do you think care changes from patients who are being actively treated to those who are actively dying?
8. What are some recommendations that you have in how the ***unit or the organization*** can better support nurses or patients in advance care planning?

Can you think of a time that you took care of a patient who was really sick and you had a discussion with them about their values and wishes at the EOL?

Describe the extent of "advance care planning" conversations (understanding of illness, expectations, helpful information about their illness, values/importance/quality of life, worries/fears, trade-offs, meaningful EOL, substitute decision maker identification)

Sub-questions:

1. How did the conversation go for you?
2. ***How*** was this conversation started?
3. ***Why*** did you start the conversation with ***this patient***?
4. ***Who*** was present?
5. What happens with this information in your organization?
6. What are some things that make it hard to have conversations about wishes and values with patients that are declining in your organization?
7. What are some things that have helped you to engage patients in this way?

Closure:

We have talked about a lot of things today. What do you think are the two take away messages that I should hear?
Is there anything I didn't ask you about that you thought I would?

Thank you again for participating in the study.

After the Interview:

1. What are the 5 most important things I heard?
2. Record a brief summary of my initial impressions and what was going on for the participant.

Appendix N: Organizational Document