The Social Relations of Home Care Nursing Work

by

Tanya Sanders

B.Sc.N., University College of the Cariboo, 1998
M.S.N., University of British Columbia, 2005

A Dissertation Submitted in Partial Fulfillment
of the Requirements for the Degree of

DOCTOR OF PHILOSOPHY

in the School of Nursing

© Tanya Sanders, 2023
University of Victoria

All rights reserved. This dissertation may not be reproduced in whole or in part, by photocopy of other means, without the permission of the author.

We acknowledge and respect the ləkʷəŋən peoples whose traditional territory the university stands and the Songhees, Esquimalt and W̱SÁNEĆ peoples whose historical relationships with the land continue to this day

The Social Relations of Home Care Nursing Work

by

Tanya Sanders

B.Sc.N., University College of the Cariboo, 1998
M.S.N., University of British Columbia, 2005

Supervisory Committee

Dr. Susan Duncan
Supervisor
University of Victoria, School of Nursing

Dr. Kelli Stajduhar
Committee Member
University of Victoria, School of Nursing

Dr. Sonya Jakubec
Committee Member
Mount Royal University, School of Nursing and Midwifery

Abstract

There is an increasing need for home care in Canada; however, there is little evidence about the everyday nursing work in home care and the institutional influences that impact this work. As nurses are the largest professional care providers in home care and given the increasing demands for home care services, there is a need to understand the work of nurses, specifically to identify the social organization of this work. As a part of a larger Canadian study on home care systems, this institutional ethnography focused on home care nurses in one health authority in Western Canada. The standpoint of nurses was explored through interviews, observations, and collected texts used to explicate the social relations coordinating home care nursing work. The results of this inquiry show that nurses' work is coordinated through texts and electronic health documentation systems. Safety, measurement, and efficiency are shown to influence nurses' work. Alongside the discursive arrangements, increasingly nurses' time coordinating their work and client care is expanding, with less time for direct client care. To meet the increasing demand for home care, insight is needed to improve access and care. Understanding the invisible but dominant ruling relations organizing influencing, and at times disorganizing, the everyday work of nurses is a vital first step in creating change for home care nursing.

Table of Contents

Supervisory Committee ii

Abstract iii

Table of Contents iv

List of Tables ix

List of Figures x

List of Abbreviations xi

Acknowledgements xii

Chapter One: Focus and Framing 1

  Background 4

  Problem Statement 7

  Purpose and Research Questions 8

  Research Strategy 10

  Overview of Dissertation 11

Chapter Two: Literature Review – The Conceptual Landscape 13

  Home as a Location of Care and Valuing of Home Care Work 14

  Home Care and the Canadian Health Care System 16

    Home Care Policy 16

    Home Care Leadership and Funding 18

    Development of Home Care in Canada 18

  Increasing Need for Home Care 19

    Increasing Need for Services – An Aging Population 19

    Increasing Need and Changing Nature of Service – Complexity and Acuity 20

The Managerial Turn in Health Care – "Saving Money" and "Not Enough Money" 21

The Work of Home Care Nurses 25

What is Home Care Nursing Work? 25

Changing the Work of Nurses 28

Social Organization of Knowledge and Knowing Home Care Nurses' Work: The Contextual Landscape and this Inquiry 29

Chapter Three: Methodology 31

Institutional Ethnography 31

Ontology and Epistemology 33

Marx's Influence 35

Feminist Influence 36

Ruling Relations 38

Implications for Institutional Ethnographic Inquiry 39

Entering into the Process 39

The Problematic 40

Language, Text, and Discourse 42

Work and Institutions 46

Data Collection and Analysis 48

Data Collection and Analysis Process for this Research Work 50

Context 50

Ethics 52

Participants 54

Access and Site of Research ... 58

Data Collection Methods and Context ... 59

Reflexivity ... 67

Analysis ... 70

Qualitative Research Conventions – Rigour and Generalization ... 76

Conclusion ... 77

Chapter Four: A "Jack of All Trades": The Work of Home Care Nurses ... 78

Home Care Settings ... 78

Nursing Roles and Implications ... 83

Before Direct Care Begins ... 86

The Morning Circus ... 86

Finding Work – Who Will I Provide Care to Today? ... 87

Scheduling the Work – Who is the Priority and When Will I See Them? ... 90

Coming to Know the Clients – What Care Will I Be Providing? ... 95

During Care – Home Visits ... 103

After The Visit ... 109

Recording the Care Provided and Entering Data ... 109

Establishing Home Supports ... 113

Referrals and Follow-Up ... 116

Determining the Next Visit ... 118

How Nurses Identify Their Work ... 119

Conclusion ... 120

Chapter Five: Findings – What Counts When Counting the Itinerary: Translating Nurses' Work into Abstract Representations 122

The Itinerary Form – Contradictory Understandings of Purpose and Use 123

What is the Itinerary Form? 124

Completing the Itinerary Process and Text 127

The Influence of Safety Policies in the Itinerary 131

The Intended Use of Safety Assessment and Actual Use: The Workarounds 135

Safety as a Requirement of Provincial Policy 136

Workload Measurement and Data Generation From the Itinerary 139

The Itinerary as a Tool to Objectify Nurses' Work 140

Quantifying Nurses' Work Through the Itinerary – What Counts? 143

What is Not Seen – Does it Have Value? 148

Chapter Six: Discussion – Completing the Circle 154

The Study Questions and Problematic 154

Safety as a Ruling Relation in Practice 157

The Itinerary Form as Tool for Planning and Efficiency 163

The Itinerary as a Process to Objectify, Count, and Measure 170

What is Missed on the Itinerary 174

Balancing the Needs of the Organization and Clients 174

Organizing Work 177

The Cost of Home Care 179

Conclusion 180

Chapter Seven: Recommendations – Opportunities for Change 182

Opportunities for Change in Nursing Practice 183

Information Systems 190

Policy 192

Research 195

Limitations of this Inquiry 197

Conclusion 198

References 200

Appendix A: Ethics Approval 222

Appendix B: Observation Consent Form 223

Appendix C: Interview Consent Form 228

Appendix D: Study Infographic and Recruitment Information Posters 232

Appendix E: Level 1 Participant Interview Guide 235

Appendix F: Level 2 Participant Interview Guide 239

Appendix G: Tackling the Home Care Challenge Observation Guide 240

List of Tables

Table 1 Participant Gender– Primary and Secondary 56

Table 2 Participant Age – Primary and Secondary 56

Table 3 Participant Nursing Designation – Primary and Secondary 56

Table 4 Participant Years of Work in Home Care – Primary and Secondary 57

Table 5 Participant Years in Nursing Practice – Primary and Secondary 57

Table 6 Texts Collected..66

List of Figures

Figure 1 Data Collection Timeline....60

Figure 2 Map of Home Care Nurse Visit....71

Figure 3 Analysis of Transcripts....73

Figure 4 Process of Moving from Work to Ruling Relations....75

Figure 5 Daily Employee Itinerary Check-In....125

Figure 6 Map of the Itinerary Process....128

Figure 7 Close-up Risk Level Checkbox Daily Employee Itinerary Check-In....129

Figure 8 Close-up Information Added in PARIS Checkbox Daily Employee Itinerary Check-In....130

Figure 9 Small Nurse Hero....150

List of Abbreviations

BC	British Columbia
BCEHS	BC Emergency Health Services
CIHI	Canadian Institute for Health Information
CNA	Canadian Nurses Association
CHNC	Community Health Nurses of Canada
COVID-19	Coronavirus disease 2019
CRT	Community Resource Team
EHR	Electronic health record
IE	Institutional ethnography
IV	Intravenous
MRN	Medical record number
PARIS	Primary Access Regional Information System
PICC	Peripherally inserted central catheter
SSAP	Staff Safety and Awareness Planning
THCC	Tackling the Home Care Challenge
VON	Victorian Order of Nurses

Acknowledgements

I acknowledge the territory that I am a guest on; I live, learn and work on the traditional and unceded territory and traditional lands of the Tk'emlúps te Secwépemc within Secwepemc'ulucw. I have spent much time walking and thinking during the writing of this dissertation and my learning during the doctoral program. The opportunity to walk on these lands, breathe the fresh air, and enjoy nature has provided space and time for me to think, to reflect, to offer both clarity and freedom of thoughts. I am grateful to live on such beautiful lands.

I would first like to acknowledge my family. The opportunity to return to learning for me was one that I looked forward to and also required time and dedication. The support of my husband made this possible. He was steadfast in his commitment to supporting my doctoral studies, and I am grateful for this. My children walked alongside me through this experience. They watched as I wrote, Facetimed when I was away for classes and data collection, talked about what I was doing, and caringly asked questions about how my writing was going. They also provided me with balance that helped me to ensure I was having fun and taking time away.

This work would not have been possible without the support and guidance of my dissertation committee. Similar to the proverb about raising children, it takes a village to raise a scholar. My sincere thanks to my stellar committee, a star lineup of scholars and mentors whom I am so grateful to have worked with. Susan, Sonya, and Kelli, your mentorship has shown me how to engage in nursing academics in a caring, critical, and authentic way. I appreciate your role modelling on how to be a good colleague and mentor, and I will work at emulating the mentorship that you have provided. Your collective commitment to quality nursing scholarship is so rich, and I value the opportunities you provided me with to learn and grow.

Never underestimate the value of a good cheerleader. Thank you to my friends and family who met me for coffee, took me skiing, went for walks with me, and asked how things were going. Sometimes we talked about this research, and other times we did not, and both were needed. Your support contributed to my ability to complete this work.

I am grateful to the faculty at UVIC who have expanded my knowledge and guided my learning. Thank you to the participants in this work who shared their experiences as nurses and were such dedicated professionals in their commitment to client care, thank you for sharing with me, for giving your voice to this work.

Chapter One: Focus and Framing

In 2019, several media reports suggested a shift in the delivery of community health services, specifically home care services, and my experience has confirmed this. On January 7, 2019, Hay (2019), a *Global News* journalist, reported paramedics in Toronto are hosting drop-in clinics in community housing buildings, providing mental and physical health support to seniors in Toronto and residents with complex needs. Hay identified the community paramedic program as an "alternative to calling 911" (para. 6). The program offers blood pressure, glucose, heart rate, and oxygen level assessments for the residents and is promoted as providing an opportunity to notice trends in participants' health (Hay, 2019). The Toronto community paramedicine program was launched in 2017 and is the first program of an Ontario-wide project that has seen the development of over 30 community paramedic programs (Ontario Community Paramedicine Secretariat, n.d.).

On January 30, 2019, Wadhwani (2019), a journalist with *Surrey Now-Leaders* news, reported paramedics in British Columbia (BC) will receive training to provide care to clients who require palliative care services at home. BC Emergency Health Services (BCEHS) along with paramedic providers in Alberta, Nova Scotia, and Prince Edward Island, received funding from private not-for-profit agencies, the Canadian Partnership Against Cancer, and the Canadian Foundation for Health Care to train paramedics "to treat pain and symptoms often felt by people with serious illness" (Wadhwani, 2019, para. 5). The BCEHS Chief Transformation Officer (as cited in Wadhwani, 2019) identified the program will "allow more patients at the end-of-life to stay at home instead of having to take unwanted trips to the emergency room to be treated" (para. 6).

On August 22, 2019, Kamloops paramedics were identified as the first in the province to receive palliative care training (Lirette, 2019). This training will prepare paramedics to offer care for patients at home, consult with the palliative care team, and address pain crises and shortness of breath (Lirette, 2019). Advanced Care Paramedic Renee Gilroy (as cited in Lirette, 2019) highlighted the program's benefits, noting that they will reduce hospital admissions, give control back to patients, and offer better access to palliative resources for those residing in rural areas.

In September 2019, as I walked through the lobby of my in-law's assisted living home, I noticed a poster advertising an upcoming health clinic. I stopped, read the note, and discovered it is a community paramedicine clinic. Local paramedics would be coming to take blood pressure and offer support and information to improve residents' health and wellness. Despite the presence of a home care nurse in the small community, the clinic is being offered by paramedics.

These news accounts, along with my own lived experience, highlight the development of new programs to address gaps in service and prevent hospital admissions for people living in the community with chronic illness or who are receiving palliative care services (Hay, 2019; Lirette, 2019; Wadhwani, 2019). Common amongst the reports is that funding has been provided for these programs through non-for-profit agencies (Lirette, 2019; Wadhwani, 2019) or the Ministry of Health for paramedicine programs (Ontario Community Paramedicine Secretariat, n.d.). Paramedics are identified as a resource to be trained and dispatched to provide care in communities (Lirette, 2019; Ontario Community Paramedicine Secretariat, n.d.; Wadhwani, 2019). While these programs offer important services, innovative thinking, and opportunities for people to engage in health activities, I noticed an absence of discussion of programs already providing care. What is missing from these media accounts is the identification of providers who are already engaged in community health and home care work including registered nurses. As an

experienced community health nurse, I am aware of the day-to-day work of nurses and other care providers who deliver essential care to clients and families. I see an incongruence between a growing need for knowledge and skills in an increasingly complex environment for home care nurses and the implementation of programs providing short training for narrowly focused tasks to address apparent gaps. Throughout this research, I use my location as a nurse to enter into the inquiry and in my engagement with nurses and their home care work. I understand the complexity and knowledge needed to provide care to people in the community and in their homes, and question how is it that the everyday work of home care nurses is not seen and is being replaced by other care providers? How have the gaps evolved, and what has led to these changes?

Nurses are the largest group of health care providers in home care (Canadian Nurses Association [CNA], 2013; Ganann, Weeres, Lam, Chung, & Valaitis, 2019); addressing nurses' work and their utilization in home care could improve client outcomes (CNA, 2013; Ganann et al., 2019). The work of nurses is integral to home care services (CNA, 2013), as they provide care across the continuum of health and illness and the lifespan (Community Health Nurses of Canada [CHNC], 2010). Home care nursing work includes disease prevention, health promotion, rehabilitation, and health restoration to prevent problems and manage existing conditions (CHNC, 2010). In 2021, Statistics Canada (2022) found 6% of Canadian households (a total 921,700 households) required home care support. The need for home care is increasing as the population ages and more people suffering chronic illness require and request care at home support (Canadian Home Care Association, 2011; Canadian Institute for Health Information [CIHI], 2017; Palmer et al., 2022). Canadian surveys also found, in the event that they require assistance, people have a strong preference to age and be cared for at home rather than in

institutions (CNA, 2014; Statistics Canada, 2022). As governments work to contain costs associated with hospital care, home care has often been identified as a lower cost option to provide care to clients (Björnsdóttir et al., 2015; Health Council of Canada, 2012). With these shifts, scholars argued care at home is placing a toll on family caregivers (Björnsdóttir, 2009; Chappell, 2011). Changing family structures and more women in the workforce than ever before mean fewer family members are available to provide care at home (Björnsdóttir, 2009; Health Council of Canada, 2012). These factors have resulted in more significant needs for home care services and nursing care.

Despite the increasing need for home care, little research has been conducted on home care in Canada, how it is organized, and its outcomes (Johnson et al., 2017); specifically, there is a lack of understanding of the work home care nurses do (CNA, 2013; Underwood, Baumann, et al., 2009). In this research, I used institutional ethnography to investigate the social organization of home care nursing work from the standpoint of home care nurses.

Background

Home care is defined as services that “help people to receive care at home, rather than in a hospital or long-term care facility, and to live as independently as possible in the community” (Health Canada, 2016, para. 3). Home care services can include nursing care, personal care, physiotherapy, occupation therapy, speech therapy, dietician services, and respite services (Health Canada, 2016). However, there are varied definitions and understanding of what home care is, and the services provided to clients and families vary significantly across the country (Canadian Health Coalition, 2018; Canadian Healthcare Association, 2009; Palmer et al., 2022). Home care is uniquely positioned in the Canadian health care system, as it is not included in the Canada Health Act (1985) as an essential service (Health Canada, 2016). There are implications

of this exclusion from the act, including a lack of common standards and services across the country, accountability for the act's principles, funding, and an ability to charge for services; therefore, there is a mix of publicly and privately funded home care services across Canada (Canadian Healthcare Association, 2009; Johnson et al., 2017).

Home care nursing is an integral component of Canada's home care programs (CNA, 2013; Health Canada, 2016). Home care nurses may be called community health nurses or visiting nurses (Ganann et al., 2019); for this research, I use the term home care nurse. Both home care services in Canada and the work of home care nurses vary significantly (CHNC, 2010). The CHNC (2010) identified the role of home care nurses as those who "are committed to the provision of accessible, responsive and timely care which allows people to stay in their homes with safety and dignity" (p. 4). Although the CHNC has developed competencies and descriptions of home care nurses' work, their role in home care remains misunderstood and underutilized (CNA, 2013).

Home care nursing work, which is unique within the specialty of community health nursing (CHNC, 2010), has its own competencies that require specific skills and knowledge to meet the complex work of providing home care nursing (Nilsson et al., 2009). In Canada, these competencies are based on a framework composed of three components: elements of home health nursing, foundations of home health nursing, and quality and professional practice (CHNC, 2010). The elements of practice in home care nursing competencies have eight nursing activities, functions, goals, and outcomes, which include assessment, monitoring and clinical decision and care planning, care coordination, teaching and education, and building capacity (CHNC, 2010). CHNC (2010) has identified the foundations of home health nursing as the core knowledge of health promotion, illness prevention, health protection, and primary health care

philosophy. The final component of home care nursing competencies is quality and professional responsibility, which focuses on activities and strategies that home care nurses carry out to promote quality of care and professional responsibility (CHNC, 2010). Nurses work autonomously in home care (Melby et al., 2018) and collaboratively with interdisciplinary coordination and leadership (CHNC, 2010; Nilsson et al., 2009). Although nurses' work in home care varies depending on the province and organization in which they are employed (Ganann et al., 2019), there is a common understanding that home care nursing work is a specialized area of practice, with the work of highly skilled nurses resulting in positive outcomes for clients and their families (CNA, 2013; Ganann et al., 2019; Melby et al., 2018).

Nurses' work in home care is often unseen, as it occurs in the privacy of peoples' homes, behind closed doors (Melby et al., 2018; Purkis, 2001). As Marrelli (2018) identified, there are distinct contextual factors in home care nursing work as nurses enter the client's home, fitting into patients' schedules and needs, which is the opposite of nursing work in acute settings, where organizational structures set timing and control. In the client's home, nurses must be flexible and adaptable, as they are guests in the client's home (Marrelli, 2018). Home care nurses provide care that is patient-centred as they engage in care in the home environment with the patient's family, friends, and pets (Sharkey & Lefebre, 2017). These factors influence the visibility and understanding of the role of home care nurses.

Many influences affect the work of nurses from the broader health system. The managerial turn in health care (Björnsdóttir, 2009; Purkis et al., 2008) has resulted in increased time constraints and inadequate time for activities with clients, a focus on tasks, and a medical model focus that restricts holistic care and health promotion (Duncan & Reutter, 2006; Ganann et al., 2019; Martinsen et al., 2018). These influences have resulted in limiting visits and

increasing reliance on family for caregiving (Björnsdóttir, 2009; Funk et al., 2020; Purkis, 2001). Of the people receiving long-term home care, 95% have an unpaid caregiver and more than one in three of these caregivers are distressed (CIHI, 2020). Purkis (2001) identified standardization of home care services as an effect of globalization, resulting in a drive to create efficiency and contain costs. The increasing complexity and acuity of clients in home care decreases the time for clients with chronic health needs (Purkis, 2001) and has increased the time nurses spend negotiating discharge information and care planning (Melby et al., 2018; Smith Higuchi et al., 2002). Additionally, there are increasing calls to optimize the scope and roles of care providers (CNA, 2013; Ganann et al., 2019) that identify the need for nurses to address more complex conditions living at home and to have role clarity to enhance communication, reduce role conflict, and support collaborative work (Ganann et al., 2019). While Johnson et al. (2017) identified influences on nurses' roles, I found a dearth of recent Canadian literature that focuses specifically on home care nursing work and outcomes.

Problem Statement

There are significant gaps in understanding the nursing work occurring every day under the umbrella of home care programming in Canada (CNA, 2013; Ganann et al., 2019; Melby et al., 2018). The influences on home care and home care nursing work need to be examined. Given the increased need for home care services (Conference Board of Canada, 2015; Palmer et al., 2022), the impacts of these demands on nursing, the broader influences changing nursing work, and the unmet needs of clients (Statistics Canada, 2022), it is essential to understand what is happening to home care nursing, examine the work of nurses, and identify what is coordinating nurses to seek opportunities for providing better care and systems change.

Purpose and Research Questions

The purpose of this research was to investigate the everyday work of home care nurses in one BC health authority using institutional ethnography to identify what the work of home care nurses is and to understand what is coordinating and directing the work of nurses in home care. In conducting this research, I employed institutional ethnography (IE), an approach to inquiry as I sought a unique and important view into the institution of home care and home care nurses' work that would reveal coordinating forces and power influencing the organization, work, and care of clients. As D. E. Smith (2005) identified, IE aims to map the ruling relations and the "institutional complexes in which they participate" (p. 51) as well as "build knowledge and methods of discovering the institutions, more generally, the ruling relation of contemporary Western society" (p. 51).

IE is based on the work of people from the standpoint of those doing the every day and every night work (D. E. Smith, 2005). Several terms such as *standpoint* and *problematic* used here are central to IE and will be explained further in Chapter 2 and used throughout this dissertation. Standpoint is a "way of directing attention to the starting place of the inquiry" (D. E. Smith & Griffith, 2022, p. 77). From this place of entry, a problematic is identified as the puzzles or rubs in the work become apparent to the researcher (Campbell & Gregor, 2008). Problematic is a methodological term used in IE that identifies the puzzle, the areas of tension between lived experience and social organization, which the researcher can engage to identify and analyze how social organization is influencing the work (Allen, 2015; Bisaillon & Rankin, 2013; D. E. Smith, 1987). Conducting a review of relevant literature, I found the standpoint of nurses is lacking in the literature. As identified earlier, nurses are not present in the media accounts celebrating new community health programs to address gaps in health systems, despite the fact that they have

previously been central to this care. Connecting with nurses in their everyday work in home care to develop an inquiry based in an IE approach offers a missing and critical view into home care. Hamilton and Campbell (2001), in their investigation into nursing standpoint and nurse staffing, identified how nurses knowledge is overlooked and "submerged" (p. 281) in decision making, how nurses are asked for their knowledge about "front-line patient care" (p. 281) and are then routinely undermined. With its focus on participants' lived experiences, IE allows for inquiry into areas and questions that may not be apparent or discovered through other research approaches (Kearney et al., 2019). As such, IE enabled me to focus this inquiry on the standpoint of nurses in home care.

Although I had many potential questions of interest within this setting, I began by observing and listening to home care nurses to identify a possible point of entry into my inquiry (Campbell & Gregor, 2008). From initial fieldwork, conversations, and observations with nurses, I identified a problematic that situated my exploration of the social and ruling relations of nursing practice in home health. Inside the broader question, I found more specific questions that were possible to examine, including what is happening for home care nurses in their work, what influences this work, and how their work is coordinated from the local to trans-local sites?

IE focuses the inquiry into the "systems level coordination of people's everyday work experiences" (Quinlan, 2009, p. 628). This inquiry into the coordination of nurses' work across sites was needed to reveal the ruling relations, power, and influences affecting home care nursing work and changes in home care programs. The goal of IE is to identify how participants' experiences are socially organized, examining patterns and how relations are coordinated through texts, language, and actions to explain the social organization of their lives (D. E. Smith, 1999). Health systems are socially organized; most of what is coordinating the work in the

system is invisible and ruled by relations of power (Carrier & Prodinger, 2014). Inquiring into the social organization of knowledge and home care nurses' work using IE allowed me to explore, identify, and discuss the ruling relations and power in home care. Understanding social organization requires an examination of the coordinating features through analysis of text and discourse to identify the social relations ruling the work. By utilizing the unique ontological stance, focusing the inquiry on nurses' everyday experiences, and looking to expose the coordinating influences across home health sites, IE presented an opportunity to address questions about what is organizing nursing practice and who has legitimized knowledge and power in the setting. Foregrounding nurses' experiences in home care recognizes nursing knowledge and identifies influences on their practice. By entering into a standpoint with the nurses whose work is being organized extra-locally and developing a problematic, as the researcher, I collected data to map out and illuminate the ruling relations coordinating actions across the local and trans-local sites.

I undertook an IE analysis that concentrated on work and texts in action, investigating these with an eye to social relations and particularly relations of ruling. True to inductive qualitative research design, from initial analysis I established two broad research questions to guide my inquiry:

1. How do home care nurses describe their work providing care to clients every day?
2. How do the work policies, processes, and institutional structures affect their work experiences?

Research Strategy

This inquiry aimed to bring light to the work of nurses in home care, tracing the institutional influences of their work to identify the ruling relations impacting nurses' work. I

based this inquiry on the foundational tenets of IE, recognizing the social ontology, critical feminist views, material consumer exchange processes of the Marxist's influence, and the standpoint of the everyday work of the nurses. IE offered an approach to the inquiry that uncovered the forces influencing contemporary home care and nursing work. With a mix of publicly funded services and private pay services, home care is uniquely positioned in the Canadian health care system (Canadian Healthcare Association, 2009; Palmer et al., 2022). The consumer choice and market-based systems that influence home care are grounded in a capitalist approach and stem from the exclusion of home care from the 1985 Canada Health Act (Duncan & Reutter, 2006). As many European researchers have noted, with the rise in the new market system, there have been significant impacts and changes to home care, including a change in funding models, a focus on decreasing costs and increasing user-pay services (Björnsdóttir, 2009; Funk et al., 2020; Genet et al., 2011).

As a critical qualitative approach to inquiry, IE offered a perspective on the contemporary institution of home care. It is one approach to research that can be used to understand the complexity of home care, and I believe it offered a valuable vehicle to explore and expose the ruling relations, sources of power, disjuncture in the work of nurses, and inequities of power and consumerism.

Overview of Dissertation

Nurses' work is highly skilled and is the most used professional resource in home care (CNA, 2013). With the increasing needs for home care, the development of programs to fill gaps without nurses, and the invisibility of nursing in the literature on home care, there is a need to understand the everyday work of home care nurses and the influences on this work. In Chapter 2 of this dissertation, I summarize the current contextual landscape. To begin the chapter, I

introduce how literature is used in IE and the difference in identifying discourse present in the literature rather than seeking theory to guide test in the research. I outline IE as the research approach for this inquiry, identifying the theoretical and philosophical foundations in Chapter 3. After introducing the approach, I describe the steps that I completed for this research. In Chapter 4, I provide an ethnographic description of the work of home care nurses. I present accounts from the data that identify tensions linking to ruling relations. I present a summary of findings from the analysis of texts, observations, and interview data in Chapter 5. From the analysis of the data, I show how ruling relations are directing the work of home care nurses. In Chapter 6, I complete the analytic circle, returning to the research questions to discuss the finding of this research. Finally, in Chapter 7, I identify recommendations for change based on the findings of this research. The troubles in home care are amenable to action to create improvements for nurses, clients, and health outcomes.

Chapter Two: Literature Review – The Conceptual Landscape

In this chapter, I summarize a review of literature to set the context of this inquiry and identify the conceptual landscape. Many research approaches begin with a literature review to establish the current state of knowledge, identify gaps, and provide theoretical frameworks that may guide the inquiry. In IE, the use of the literature to inform and guide the research approach differs from other research methodologies, as the researcher seeks to examine what has been published on the topic of interest and identify what knowledge has been generated, which helps frame what is known conceptually about the issue but does not set the line of inquiry (Campbell & Gregor, 2008). The researcher can use the literature to establish their position, analyze the literature's social location, and identify the current discourse and authorized knowledge (Campbell & Gregor, 2008). In this way, the IE literature review is different from other research approaches where theory is foregrounded and the literature located is taken up to guide the study process and questions. In IE, literature is used to set the context for inquiry, identify the common discourses, and draw out how the discourses are directing the social organization of knowledge, rather than utilizing the literature to direct the questions and process; this maintains the focus and perspective of those with the lived experience and the view to identify what is going on in the everyday.

To identify the conceptual landscape and discourses in home care nursing, I completed a search of published and grey literature, including policy documents and media accounts. I searched for terms including home health, home care, community health, nursing/nurses/nurse, registered nurse, nursing roles, and combinations of the terms. When reviewing the results, I sought to identify what is known about home care nursing work, what shifts in policy and practice have resulted in the current state of home care. In this chapter, I discuss the common

discourses identified through this review process, including home care as a location of care and valuing of home care work, home care as a part of the Canadian health care system, increasing need for home care services, and the work of home care nurses. This summary provides a view of the current conceptual landscape of what is known about home care nursing work relevant to this inquiry. As discussed earlier, there is a lack of current Canadian research focussed on home care nursing; as such, the literature summarized in this chapter integrates international publications that are current alongside Canadian literature published in the 1990s to the mid 2000s. In their recent realist review of home care literature, Contandriopoulos et al. (2022) also identified gaps in the literature on home care pointing to the need for continued study.

Home as a Location of Care and Valuing of Home Care Work

Within the literature, several discourses about the home as a location of care are discussed, including how being in homes contributes to a lack of understanding about the work of home care, the unique work of entering into peoples' homes to provide care, and challenges for home care providers in being in a home setting. These ideas are set in the context of a prevailing understanding that home is the preferred option for care, as the home is where people want to receive care, remain to age, and possibly die (CNA, 2014). A Canadian Nanos poll identified 96% of Canadians think it is important or somewhat important to age at home with access to health care in their home settings (CNA, 2014). However, providing care in people's homes results in the work of home care as unseen and, therefore, unknown because of the private setting (Purkis, 2001).

Work occurring in the sanctuary of peoples' homes requires negotiating care and entry (Björnsdóttir, 2018; Latimer, 2012; Martinsen et al., 2018; Melby, 2018). As Sharkey and Lefebre (2017) identified, entering into the client's home is very different from the client coming

through a health care door. Each home setting is unique and complex, differing from the uniformity of an acute hospital setting (Strandås et al., 2019). Being a guest in the client's home requires navigating the client's wishes, professional expectations, relationship development, and ethical considerations (Björnsdóttir, 2018; Grypma et al., 2012; Martinsen et al., 2018; Melby, 2018). Working in home care can result in unique benefits because of the location of service; health care providers identified they enjoy the autonomy, problem solving that is required, and strong relationships with clients and families (Grypma et al., 2012; Martinsen et al., 2018). However, there are also challenges to providing care in homes, including isolation from colleagues (Melby, 2018), safety concerns (Ganann et al., 2019), and working in environments that were not designed for health care delivery (Melby et al., 2018).

While home care is predominantly identified as being provided in homes, it is also a community-based service provided in clinics, schools, or workplaces (Community Health Nurses of Canada, 2019). For some clients, care at home is not an option because it is not safe (Latimer, 2012), or they do not have a home; therefore, a full spectrum of home care services is needed. Drawing attention to issues relating to providing care in the home is important; however, the work of nurses in home care that occurs outside of the home environment must also be noted.

While the location of care is valued, the work provided in home care is often undervalued; the tasks of home care and work associated with care for the body are often identified as domestic, nonintellectual and task-oriented undervalued (Purkis et al., 2008). Home care is undervalued and underpaid work that "has become a gendered ghetto for marginalized women" (Purkis et al., 2008, p. 27). Case management can also be undervalued and represented as just coordinating others' activities (Purkis et al., 2008), which is in contrast to nurses' descriptions of the complex coordinating work that is critical to client care in home care

(Björnsdóttir, 2018). The location and nature of work in home care impacts the ability of the work to be seen and valued.

Home Care and the Canadian Health Care System

Home care is a system of services providing care to people in community settings, including their homes, to help people remain in their homes and communities (Health Canada, 2016). Home care is more than care provided in a home; it is a community-based service provided in homes, clinics, schools, or workplaces (Community Health Nurses of Canada, 2019). Home care programs are complementary programs that do not replace the caregiving roles of the family, friends, community, and individual responsibility for self-care and management (Canadian Home Care Association, 2011). As home care programs include health and social services, there is often a division for clients on which services are accessible, funded, and available, and which services they need to safely live and be well in the community (MacAdam, 2004).

Home Care Policy

Health care in Canada is governed by federal and provincial governments, with responsibilities split between the levels of government (Lanoix, 2017). The federal government disperses federally collected tax dollars to provinces and territories to fund medically necessary health services defined as hospital, physician, and surgical, dental services (Canada Health Act, 1985; Lanoix, 2017). The Canada Health Act (1985) identified that to receive federal health funding, provinces and territories must meet the five principles in the act: public administration, comprehensiveness, universality, portability, and accessibility. These principles and the funding structure identify the values around equity, access, and fairness for health care in Canada (Clark, 2007).

As a community-based health service, home care is not included in the Canada Health Act (Health Canada, 2016). This exclusion has resulted in significant differences in access and equity for home care (Johnson et al., 2018); variations in how programs are funded, managed, and accessed across the country (Canadian Home Care Association, 2011; Sharkey et al., 2003); and a lack of oversight and monitoring for quality (MacAdam, 2004), producing a fragmented approach to service delivery and gaps in accessibility (Sharkey et al., 2003). The Health Council of Canada (2012) confirmed this by stating,

> There is no shared understanding of what home care should look like for Canadian seniors—no shared vision, common principles, or collective standards—and in the absence of this, there is significant variation in what is happening across the country, such as the types and hours of publicly funded home care services that people can received. (p. 8)

The provinces and territories have developed their own systems for home care (CIHI, 2019) and, therefore, determine the scope of services that will be funded by the government, how to deliver those services, and how they will evaluate home care programs in their jurisdictions.

The exclusion of home care from the Canada Health Act (1985) is a central governance issue that cascades into several other policy problems for home care. Many policy suggestions exist to address these concerns, including adding home care to the Canada Health Act (Romanow, 2002), re-examining funding of home care (Canadian Health Coalition, 2018), developing a national home care policy (Sharkey et al., 2003), and identifying national platform of services (Romanow, 2002) and national home care standards (Canadian Home Care Association et al., 2016). Furthermore, there has been increasing calls to action, such as in the recent federal mandate letter for the Minister of Health, in which Prime Minister Justin Trudeau

identified home care as one of the four priority areas for the Minister, directing the minister to "continue to make home care and palliative care more available across the country" (Trudeau, 2019, para. 18). With the coronavirus disease 2019 (COVID-19) pandemic, the CNA (2020) identified home care as a necessary program to work in tandem with long-term care systems to "ease pressure on the acute-care system and eliminate many of the gaps in the continuum of care that too often result in previously independent older people landing in the hospital or long-term care" (p. 5). Despite decades of recommendations, actions to address home care have not occurred from the federal government (Johnson et al., 2017).

Home Care Leadership and Funding

Leadership and funding for home care programs remain a bifurcate responsibility between the federal government and the provincial and territorial governments. This governance model is similar to other jurisdictions; European home care models also identify the split between federal oversight and regional/local design and delivery of programs (Genet et al., 2011). Home care is dynamic and complex as it is governed by multiple levels of policies and is funded and managed by national, provincial, and regional authorities (Canadian Home Care Association, 2011).

Development of Home Care in Canada

Home care existed long before there was the Canadian health care system, as the home was where sick people were attended to and cared for, and hospitals were for those who did not have family or a home (Grypma et al., 2012). Early accounts of the Victorian Order of Nurses (VON) indicated district nurses and cottage hospitals were envisioned as a part of the VON in Canada as early as 1896 (Gibbon, 1947). With the changing status of hospitals, health care reforms, education shifts for nursing, and the role of physicians, home and hospital care took on

a different importance for the care of the unwell; hospitals became the desirable place to take care of the ill, and nurses began home visiting as charitable care for the poor (Grypma et al., 2012). Over time, the Canadian health care system adopted regulatory frameworks and funding agreements (Johnson et al., 2017). In the 1970s, publicly funded home care programs were formally established in Manitoba and Ontario (Canadian Home Care Association, 2011; Sharkey et al., 2003). These programs continued to develop in other jurisdictions in Canada; currently, nine provinces have legislation for publicly funded home care, and all provinces and territories provide a variety of home care services (Canadian Home Care Association, 2011). In addition to the provincial programs, the federal government retains responsibility for home care programs delivered to veterans and Indigenous communities through the First Nations Inuit Health Branch (Sharkey et al., 2003). These independent home care programs vary in the services provided, how services are funded, and in who provides care. Home care has a long-standing history in Canada as a health and social service, and the ongoing development of home care programs represents a return to what was once the norm in health care (Grypma et al., 2012).

Increasing Need for Home Care

The increasing need for home care services is well established in both published and grey literature (Canadian Healthcare Association, 2009; Canadian Home Care Association et al., 2016; CNA, 2013; Chappell, 2011; Garland Baird & Fraser, 2018; Johnson et al., 2017; Johnson et al., 2018; Palmer et al., 2022). A variety of influences impact the need for home care services and the ways to address these needs differ.

Increasing Need for Services – An Aging Population

The growing population of older people in Canada increases the need for home care (Canadian Health Coalition, 2018; Canadian Home Care Association, 2011; CIHI, 2017;

Conference Board of Canada, 2015; Johnson et al., 2018). The current health care capacity is not sustainable and is unable to meet the impending needs (CIHI, 2017). In 2021, 10.3% of the Canadian population were 75 years old and older (Statistics Canada, 2021); this population is expected to double over the next 20 years (CIHI, 2017). People aged 75 years and older rely most heavily on health services (CIHI, 2017). The Health Council of Canada (2012) reported that seniors represent more than 75% of the home care clients, while 25% of home care services are provided to children, families, and people living with disabilities. With the significant number of users of home care services being people over the age of 65, the implications of the aging population will influence an increased need for home health.

Increasing Need and Changing Nature of Service – Complexity and Acuity

Changes in health systems, technology, and the nature of health conditions also increase need for home care and the types of services provided (Canadian Health Coalition, 2018; Canadian Home Care Association, 2011). Health systems restructuring has resulted in the shift of services and clients from delivery of services in acute care settings to community settings (Denton et al., 2002; Ganann et al., 2019; Heitlinger, 2003). This shift has resulted in greater numbers of clients receiving home care services, an increase in the acuity and complexity of care needs, and a focus on clients' medical and technological care (Denton et al., 2002; Ganann et al., 2019; Heitlinger, 2003). The changing and increased use of technology in health care, such as the ability to have day surgeries and outpatient treatments, has decreased length of stay in hospitals, improved life expectancy, expanded the ability for care to be provided at home, and increased home monitoring to support independent living (Aronson, 2019; CNA, 2013; Denton et al., 2007; Johnson et al., 2018). These technological advances have contributed to clients being discharged home earlier, with more complex needs (Heitlinger, 2003; Sharkey et al., 2020).

Additionally, the growing population of people living with chronic illnesses requires ongoing supportive care, not curative medical care (CIHI, 2017). People living with chronic illness often identified as “heavy users” of home care services are often seen as a problem, as their service needs fall outside the limited resources and time constraints that are restricted in the current rationing of services approach to home care (Canadian Health Coalition, 2018). As Funk et al. (2020) identified, home care in Canada is increasingly shifting away from the care of chronic conditions to short-term services. The focus on illness care and the increasing use of the community as a setting of care rather than a holistic approach to care is highlighted as a concern in Schofield et al.’s (2011) work with community health nurses visioning the future of nursing. The biomedical influence is identified as creating a focus on funding illness care rather than wellness care in the community (Schofield et al., 2011).

The Managerial Turn in Health Care – “Saving Money” and “Not Enough Money”

The development of home care programs in Canada is linked to health reforms aimed at shifting care from expensive acute services to home and community care with a goal to save money and reduce health care expenses (Denton et al., 2007). Home care is represented as a cost-savings program and a less expensive alternative to providing care in hospitals and long-term care settings (Chappell, 2011; Health Council of Canada, 2012). Since the initial shifts and investment in home care, there has been rapid growth in home care services without a corresponding growth in resources (Denton et al., 2002). In 2017–2018, home care in Canada represented 3% of total health expenditures ($9.2 billion; CIHI, 2019). The notion of saving money restricts the system, impacting client care (Funk et al., 2020) and the work of nurses (Ganann et al., 2019).

On an individual level, the lack of funding for home care impacts client care as restrictive allocation policies limit time with clients (Purkis, 2001; Sharkey et al., 2003). Home care is increasingly only available for short-term, acute needs, which leaves less urgent, chronic, and daily care to informal caregivers with limited resources (Canadian Home Care Coalition, 2018; Funk et al., 2020; Palmer et al., 2022). Budget constraints have resulted in restrictions on time to provide care to clients and increased workload with more clients assigned per health care providers (Denton et al., 2007; Strandås et al., 2019). With greater demands on health care providers' time, there is an increased focus on tasks and a decreased focus on relational care and prevention (Björnsdóttir, 2018; Chappell, 2011; Denton et al., 2007; Strandås et al., 2019). Funk et al. (2020), in their ethnographic study of structural empowerment between nurses and families, shared that nurses identified their work within the context of constraint, sharing how this affects their practice, resource and budget restrictions impacted their time, and the services and supports they could offer clients, which often resulted in requiring family involvement to provide home care. The restriction of services and the creation of scarcity of services invokes a notion of control from the state and a need to limit services, funding, and support (Purkis, 2001). Unmet needs and dissatisfaction with care emerge as concerns when funding is restricted for home care programs (Johnson et al., 2018; Sharkey et al., 2003).

The representation of the funding problem as a scarcity of funds supports managerial practices in health care. Managerial practices focus on efficiency, cost containment, and improving quality (Björnsdóttir, 2009; Strandås et al., 2019). Standardization of care has also been used to contain costs (Sharkey et al., 2003). However, the challenge of the funding model and standardization is that organizing care by unit makes it difficult for nurses to provide high-quality care, as care is task-focused and fragmented, which leads to gaps, challenges in

communicating and coordination, and duplication of services (Sharkey & Lefebre, 2017). Duplication of services can include home support work such as providing help to clients with their daily medications and getting up and dressed in the morning being provided by both public and private providers.

Not unlike health and public services, generally, home care is shaped by a neoliberal ideology that supports a market-based system to pay for services (Duncan & Reutter, 2006; Funk et al., 2020), leaving clients and families paying for services based on income tests and cut-offs. With home care excluded from the Canada Health Act (1985), each province has established its own funding structure for home care, including what services are paid for by the province, how much will be paid for, often through income testing and cut-offs, and what services are privately contracted (Johnson et al., 2018; Sharkey et al., 2003). With the introduction of private providers, there is an increased marketization of the care system that results in competition for contracts and a focus on the volume of service provision to meet contract obligations (Denton et al., 2007; Sharkey & Lefebre, 2017). In Ontario, the use of contracted services resulted in an increased focus on the business side of providing care, rather than the provision of care, as well as staff shortages, less organizational support, work intensification, and decreased job satisfaction with an increased propensity for staff to leave (Denton et al., 2007). Competitive contracted home care service programs negatively impact staffing levels and staff mix (Armstrong-Stassen & Cameron, 2005; Denton et al., 2007).

Financial cutbacks and the changing eligibility for home care services have resulted in unmet needs among older adults (Johnson et al., 2018). A 2018 Statistic Canada report identified one third of adults living in the community and receiving home care services had unmet needs (Gilmour, 2018; Statistics Canada, 2022). Families and friends take up the tasks to address these

unmet needs, adopting the role of caregiver (Funk et al., 2020; Palmer et al., 2022). Home care relies on the involvement of over 2 million unpaid caregivers, who provide an estimated $25–26 billion in unpaid care each year (Hollander et al., 2009). The neoliberal influence on home care supports a shift to self and family care to reduce expenses (Björnsdóttir, 2009). For people who have caregivers, there is high expectation and responsibility transferred to the caregivers with little care and support for them, which has implications for their health and well-being. (Björnsdóttir, 2009; Chappell, 2011). Women comprise the majority of caregivers (Björnsdóttir, 2009; Chappell, 2011; Health Council of Canada, 2012); however, as structures in society change, resulting in more women being employed outside of the home, there is a decreased availability of unpaid caregivers (Björnsdóttir, 2009). This leads to an increased need for paid caregiving and increased social pressure on women to assume the caregiving role (Björnsdóttir, 2009; Chappell, 2011). Caregiving remains unseen, undervalued, and underrepresented, and there is a significant need for caregivers' support and services (Canadian Healthcare Association, 2009; Health Council of Canada, 2012; Øydgard, 2017).

Due to the managerial turn in health care and limits to budgets, much of the work carried out by nurses has been "rendered invisible and therefore obsolete" (Björnsdóttir, 2009, p. 733). This invisibility has been accomplished through rules such as limiting the amount of services offered or the length of service and through strategies such as encouraging self-care and independence in clients (Björnsdóttir, 2009). Neoliberal influences and budget controls impact the work of nurses. Home care nurses are responsible for assessing care needs and financial ability to pay for service, navigating the paradox between providing health care and setting up plans for people to pay for that care (Melby et al., 2018); Austin (2011) asserted navigating this tension for nurses is incommensurable.

The Work of Home Care Nurses

What is Home Care Nursing Work?

Home care has existed in Canada for hundreds of years (Grypma et al., 2012), and nurses represent the largest group of care providers in home care (CNA, 2013; Ganann et al., 2019). The nursing role in home care is identified as vitally important (Hermus & Stonebridge, 2017), yet there is surprisingly little written about the home care nursing role and the work of nurses. The World Health Organization's (2020) *State of the World's Nursing* report identified the autonomous and collaborative role of nurses in providing care to clients in many different settings of practice and across the lifespan, highlighting the critical role nurses have in integrated care and palliative care as primary providers of care. Nurses have the knowledge, skills, and abilities to lead and collaborate with interdisciplinary teams, engage across systems, and focus on client needs rather than systems tasks if they have the time, support, and resources to carry this out in their home care work (CNA, 2013).

In home care, nurses conduct assessments and develop care plans (Smith Higuchi et al., 2002); provide wound care, medications, and intravenous treatments (Martinsen et al., 2018; Smith Higuchi et al., 2002); coordinate care (Martinsen et al., 2018; Melby et al., 2018; Smith Higuchi et al., 2002); and determine eligibility for services and funding (Melby et al., 2018; Purkis et al., 2008; Smith Higuchi et al., 2002). Coordinating care work is increasing for many nurses as the trajectory of care for clients becomes more complex (Melby, 2018). Advocacy, documentation, integration of family data, and patient education are also identified as part of the home care nurse's competencies or roles (Smith Higuchi et al., 2002). Funk et al. (2020) identified nurses' time with clients during home visits is centred around information collection, receiving updates, monitoring changes, and establishing plans of care with the client and family.

Recent research in Norway identified home care work in three distinct positions: assessment, advanced procedures and medical follow-up, and providing customized solutions in various homes (Fjørtoft et al., 2021). Smith Higuchi et al. (2002) identified several processes and challenges for home care nurses in their work to develop client-centred care plans, including the imperative to establish a therapeutic relationship, the challenge of matching client needs to resources, coordinating client care required negotiating, organizing and scheduling within budget limitations and through establishing working relationships with other health care professionals.

Home care nurses' relational work is central to the care provided (Björnsdóttir, 2018; Strandås et al., 2019). Nurses identified developing a relationship with clients is a positive factor contributing to job satisfaction and retention (Tourangeau et al., 2014). Funk and Stajduhar (2013), in their research with family caregivers and home care nurses, identified the concept of relationship being beyond interpersonal relationship, as it extends to the ability to provide competent and appropriate care while promoting feelings of trust, familiarity, security and comfort. From the perspective of the family caregiver, this research affirmed that relationships between care providers and families are important for nursing care, care satisfaction, and care experiences (Funk & Stajduhar, 2013).

As previously noted, home care nurses work with clients who have increasingly complex care needs within autonomous and independent settings (Melby, 2018). Due to the increase in clients' acuity, homecare nurses required more advanced clinical assessment and procedural skills (Melby et al., 2018). In a study of over 1,000 Canadian community health nurses, Armstrong-Stassen and Cameron (2005) identified clients' vulnerabilities and increasingly complex needs were among their top four work-related concerns. Similarly, in their research with Canadian community health nurses, Schofield et al. (2011) highlighted that, because of the

increasing acuity in client needs, there is a decrease in the holistic approach and a lack of resources and knowledge to adequately meet clients' needs.

Home care is an interdisciplinary endeavour with clients needing care from family, health care assistants, nurses, occupational and speech therapists, physiotherapists, physicians and nurse practitioners. Nurses are often central in the interdisciplinary team and have a role in the communication of information and coordination of care (Canadian Home Care Association, 2018; Melby et al., 2018; Tourangeau et al., 2014). Björnsdóttir (2018) identified the relational and collective work of home care nurses who aimed to build a net of services to support clients; this work involved organizing work and translating client narratives into the organization so that their needs could be met.

Nurses' work changes with the increasing external management of nurses' time, tasks, and priorities and the use of standardized checklists, which impact their ability to effectively engage in relationships with clients (Björnsdóttir, 2018; Fjørtoft et al., 2021; Strandås et al., 2019). With the growing complexity of clients, there is an increased demand for nurses' experience and competence (Nilsson et al., 2009; Strandås et al., 2019). Home care nurses apply theoretical, experiential, and evidence-based knowledge in a highly autonomous scope of practice (CHNC, 2010). They make complex client assessments to guide practice decisions, including the delegation of care to support and family caregivers (Nilsson et al., 2009). Increasingly, nurses are taking on case management roles and are determining the specific services and allocation of resources for the provision of services (Melby et al., 2018; Purkis et al., 2008). This transactional role causes nurses to focus on payment and creates a dichotomy between determining economic eligibility and caring needs and practices (Purkis et al., 2008). Whether the nurse or another health care practitioner determines the services to be delivered, it is

the nurse who prioritizes and defines what interventions and practises will be employed on any particular visit (Martinsen, 2018).

Changing the Work of Nurses

Although the work of nurses is not well documented in the literature, there is emerging discussion on nursing roles in home care within the discourses of "optimization" (Ganann et al., 2019, p. e604) and "task shifting" (Denton et al., 2015, p. 485). Ganann et al.'s (2019) scoping review identified 127 papers published between 2002 and 2015 that addressed the optimization of nurses in home care. The CNA (2013) defined optimization as "determining how competencies can be used to the best advantage" (p. 7). This work includes removing divisions within nursing as well as those external to nursing to facilitate interprofessional and collaborative practice; these processes support best outcomes for clients and the best use of human resources (CNA, 2013). There continues to be a lack of understanding of community health nursing roles, of which home care nursing is a part; this affects the mandate and policy for home care work (Underwood, Baumann, et al., 2009). Along with the lack of clarity, there is a projected shortage of community health nurses to meet the growing service needs (Underwood, Mowat, et al., 2009). Community health nurses identified their scope of practice is being underutilized, reduced, and misunderstood, leading to nurses being devalued and replaced by other disciplines (Schofield et al., 2011). Ganann et al. (2019) suggested the optimization of nurses' roles is required because of the growing need for home care and the potential impact nurses can have to positively influence client outcomes.

Task shifting (i.e., the redistribution of tasks) refers to transferring tasks from regulated professionals to unregulated care providers to reduce costs and provide care to more clients (Denton et al., 2015). Denton et al. (2015) identified the positive and negative impacts of task

shifting on quality of care from the perspective of care providers, with home care workers seeing task shifting as improving quality of care due to increased consistency of care provider and trust, and nurses and other home care professionals identifying concerns about the quality of care due to a lack of knowledge, education, and training for complex tasks and scheduling changes that may interrupt the ability to provide continuity of care.

With decreasing numbers of health care workers available to provide the needed care in homes (Canadian Home Care Association, 2011), the discussion on optimization and role and task shifting will continue. The CNA (2013) identified leadership, health systems alignment, nursing proficiency, interprofessional respect, and technology as enablers of nursing optimization. While there may be opportunities for nurses to expand their roles in home care, there are also barriers to practice and a continued lack of role clarity that leads to an underutilization of nurses in home care (CNA, 2013). Nursing care in home health has demonstrated positive effects on client outcomes (CNA, 2013). The ideas of optimization and task shifting impact nurses' work and highlight tensions at play in identifying who is providing what care to clients and are part of the contextual landscape affecting how home care nursing work is thought about and implemented in practice.

Social Organization of Knowledge and Knowing Home Care Nurses' Work: The Contextual Landscape and this Inquiry

These discourses affect the work of nurses in home care and highlight a need for inquiry. As previously identified, the increasing need for home care services (Canadian Healthcare Association, 2009; Canadian Home Care Association et al., 2016; CNA, 2013; Chappell, 2011; Garland Baird & Fraser, 2018; Johnson et al., 2017; Johnson et al., 2018), changing complexities of care (Denton et al., 2002; Ganann et al., 2019), and the managerial turn in home care

(Björnsdóttir, 2018; Chappell, 2011; Denton et al., 2007; Strandås et al., 2019) impact the programs, care delivered, and work of home care nurses. What is discursively going on in this contextual landscape may be different from what is occurring in the everyday work of nurses, yet it shapes that work. The ability to learn from a nursing perspective, expose and understand the coordination of the social and ruling relations with the view to create change is critical. A standpoint in nursing is needed. As Allen (2015) highlighted,

> All too often prescriptions for nursing have arisen from armchair theorizing about what nurses should do rather than research into what they actually do and an understanding of how this role function is shaped by the context in which they work. (p. 7)

Taking up the standpoints of those excluded from the institutional discourses but governed by them is central to an inquiry using IE (Grahame, 1998). There has been little discussion on the work of home care nurses, specifically on how home care nurses' work is organized within the larger context of institutions. As an approach to inquiry, IE aims to uncover the ruling relations, mapping out the location and influences of power on the everyday work of the participants (D. E. Smith, 2005). Utilizing IE in this inquiry allowed for an important and timely exploration into the social organization of home care nursing work in Canada.

Chapter Three: Methodology

This research aimed to explicate influences impacting home care work from the standpoint of nurses. IE was utilized as the research approach to both describe home care nurses' work and to extend the view beyond the day-to-day to show the discourses[1] coordinating nurses' work. IE is needed to highlight the ruling relations, including discourses and power impacting home care nursing, so that effective change can be created. In identifying the ruling relations, opportunities for change and political stimulus for transformation can emerge (Adams et al., 2015). In this chapter, I outline IE as the methodological approach for this inquiry, and I identify the theoretical and grounding and philosophical foundations of IE, with a particular focus on the social organization of knowledge underpinning IE and this research. In the first part of this chapter, I integrate how I used IE in this inquiry to explore the work of home care nurses and show ruling relations coordinating their work, and in the second part I share how I carried out this research using IE.

Institutional Ethnography

IE is a critical qualitative research approach developed by sociologist Dorothy Smith (Campbell & Gregor, 2008; D. E. Smith, 1987, 1990, 2005). Created with influences from feminist and Marxist ideologies, IE is directed by a particular understanding of social ontology and epistemology (D. E. Smith, 1987, 2005). An IE starts with people's everyday experiences, identifying a place of tension in their day-to-day work to uncover power relationships and dominant discourses (D. E. Smith, 2005). Institutional ethnographic inquiry moves beyond

[1] Discourse in IE is about institutional practices that are actively created through texts and organize the work—what is written, said, or done (D. E. Smith & Griffith, 2022). This is distinct from discourse analysis or Foucauldian analysis in that IE discourse conceives that discourse exists because of people's engagement with textually mediated social relations (Bisaillon, 2012).

objectifying or theorizing about people's work to provide a view of the coordinating features and power influencing their everyday work. As an approach to research, IE provided me with an opportunity to identify, map, and learn about the coordinating influences on home care nursing. Starting with learning about the work of nurses in home care, IE directed the inquiry to identify which institutional processes are coordinating their work that may not be seen by the nurses who are doing the work (Campbell & Gregor, 2008; Grahame, 1998; D. E. Smith, 1987, 2005, 2006b; D. E. Smith & Griffith, 2022). The value in utilizing IE for this inquiry into home care was the ability to bring forward home care nurses' experiences, identifying what is coordinating their work, and highlighting their knowledge of what they are directed to do in their work versus what is done.

As an alternate sociology, IE was influenced by the founder, D. E. Smith's (2005) involvement in the feminist movement, her work as a mother and scholar (DeVault, 2006). D. E. Smith (2005) questioned the bifurcation of work and knowledge and traditional sociological research methodologies to develop a new approach to knowledge development and inquiry. D. E. Smith (2005) wove together a new sociology that examines work processes and the social relations of knowledge from the everyday experiences of people (DeVault, 2006). IE aims to build knowledge and identify ruling relations[2] through the mapping of relations (D. E. Smith, 2005). IE does not aim to describe actions in terms of a theoretical system, but rather seeks to learn "from their experience and with tracing how their everyday lives and doings are caught up in social relations and organization concerning the doing of others" (D. E. Smith, 2005, p. 61). In

[2] Ruling relations are those that organize people's everyday lives, are replicated through texts, and obscure or stand-in for people's experience (Bisaillon, 2012; D. E. Smith & Griffith, 2022).

this inquiry, my aim was not to describe or theorize about nursing work in home care, but rather to learn from nurses about their work in order to trace the social relations influencing their work and to describe the influences, discourse, and power that is coordinating nurses' work.

Ontology and Epistemology

Social ontology, utilized in IE, identifies that social is real (D. E. Smith, 2005). The world is "invariably social and that the only way we can be in the world is as social beings" (Campbell & Gregor, 2008, p. 27). Maintaining that people are the knowers, the social becomes the object of inquiry, focusing on how activities are coordinated through ruling relations (D. E. Smith, 2005). The ontological shift in IE requires recognition that activities and actions are not random but instead purposefully coordinated (Campbell & Gregor, 2008). These coordinating features, which occur outside of people's awareness, are named social or ruling relations; the interactions of the relations and the coordinated activities constitute social organization (Campbell & Gregor, 2008). For example, in home care nursing, the routine organization of the day is common across sites; how nurses take in information, process and create their work schedules is influenced by systems and policies outside of their view, not identified by them, but ingrained in their work processes, coordinating influences that are not seen. The ontology of IE includes that different experiences and perspectives will be generated from the social, the coordination of activities is fluid and continual, and language has a role in the coordination of social from local to trans-local, moving the coordination of activities outside the knower's view (D. E. Smith, 2005). In this inquiry, this ontological understanding required me to look for the ways that nurses work and examine how knowledge about and for that work is organized by systems, processes, texts outside their control and beyond what the nurses can see or identify.

Knowledge is socially created, and social relations coordinate the actions of knowledge making. “A social relation is not an abstraction, but rather the actual linking and coordinating of activities and work processes in diverse sites” (Grahame, 1998, p. 351). These beliefs of reality situate the approach to inquiry I took in examining home care nurses’ everyday experiences. Examining social relations, language, and text important within dominant discourses was crucial in the inquiry process and took my gaze to the coordinating features that move from the local site of work to other sites. Mapping texts used by the nurses, their actions, and their processes also revealed how knowledge is organized, the structures, and influences on knowledge, behaviours, and actions in the nursing work. Analysis of discourses and mapping texts were, indeed, central activities for my study and served a number of key knowledge making goals.

The epistemological understanding in IE moves away from realist, objectivist views of knowledge and is identified as an “alternative to the objectified subject of knowledge of established social science discourses” (D. E. Smith, 2005, p. 10). Scientific discourse is part of and is integrated into ruling relations through text-mediated, complex relations that connect across location, time, and organize everyday life (D. E. Smith, 2005). IE does not objectify or remove knowledge of the social from informants’ experiences; knowledge and knowing are deeply situated and connected to the work, the language and texts of the informants (D. E. Smith, 2005). IE’s goals are to identify and map out ruling relations, the influences that coordinate the work in the local and trans-local sites, by empirically tracing texts (D. E. Smith, 2003). Given that IE seeks to identify how work is “being put together systematically, but more or less mysteriously and outside a person’s knowledge, and for purposes that may not be theirs” (Campbell & Gregor, 2008, p. 18), the analysis must, therefore, begin with and return to people’s experience in their everyday work. It is not the work that is the object of investigation; rather, it

is the “entry point into the social relations of the setting” (Campbell, 1998, p. 57). Through the tracing and identification of the coordination of activities, research can identify how the dominant forms of power are socially organizing the work (Grahame, 1998). As Campbell and Gregor (2008) stated, “Institutional ethnography makes use of the socially-organized character of everyday life to explore its puzzles” (p. 29).

From this epistemological view, IE focusses the understanding of what is known in the social and everyday work of people. In this inquiry, my initial analysis focused on mapping and tracing how the work was carried out, the processes and texts used, the connections to procedures, policies, and people. I then questioned and identified through the mapping influences in these discursively arranged work processes. This intentional shift to looking up into the coordinating features of the work is central to IE and is a required component and understanding of the work of home care nursing.

Marx’s Influence

The understanding of social relations and organizations in IE is influenced by Marx’s philosophy (as cited in D. E. Smith, 2004). D. E. Smith (2004) identified Marx’s epistemology, ideology, and thinking as informing the development of IE as a method of inquiry. Marx asserted (as cited in D. E. Smith, 2004) consciousness and people’s activities cannot be separated; consciousness is embedded in activities, social relations, and the economic and technological level in which they exist. This focus on relations and the interconnection with the social play a vital role in IE’s understanding of the everyday work of people such as home care nurses and their work. In Marx’s views (as cited in D. E. Smith, 2004), social relations are produced from historical conditions, influenced by class and work, and coordinate peoples’ practices.

Furthermore, the political economy is an expression of the social relations of a mode of knowledge production (D. E. Smith, 2004). Language is "the actuality of thought" (D. E. Smith, 2004, p. 451). In a summary of Marx's epistemology and method, D. E. Smith (2004) shared that in Marx's views, history generates social relations, social relations are expressed in categories, and categories are forms of thought in which social relations come to consciousness. Social relations can be explored as an "integral component of capitalism" (D. E. Smith, 2004, p. 455). The understanding of social organization, and relations coordinating actions and influencing and being influenced by the conditions and interactions are integral to IE and are strongly influenced by Marx (as cited in D. E. Smith, 2004). Notions of power, oppression, and subornation are critical components of Marx's (as cited in D. E. Smith, 2004) influence, which I identified in this IE with home care nurses whose everyday is shaped by the powerful discourses outlined in the previous chapter.

Feminist Influence

The feminist movement brought forward questions of power and dominance in society and, for research, highlighted these same questions about knowledge development. For instance, who has the power to bring forth particular types of knowledge, and what knowledge is valued and foregrounded? Questioning the objectification and privileging of knowledge also occurred. Through her involvement in the feminist movement, D. E. Smith (2004) used her questioning stance to consider how research could be approached differently. In developing IE as a sociology for people, D. E. Smith (2004) identified the IE approach is not a sociology of people but rather *for* people. This distinction positions the approach to work with people and not one that takes an objective stance external to the people, placing them in a role of observed and classified with little or no power. Feminism and sociology for people rings true for home care nurses' whose

work for and with people is intimate and personal, yet highly coordinated from the impersonal discourses described earlier.

Standpoint is another guiding assumption within IE that emerged from the feminist influence. D. E. Smith (2005) asserted in working from the standpoint of the people their experiences and knowledge are not essentialized; this approach recognizes the position of those living the experiences as experts. In particular, D. E. Smith (2005) highlighted "women's standpoint not as a given and finalized form of knowledge but as a ground in experience from which discoveries are to be made" (p. 8). In seeking to understand people's lived experiences from their position and experiences, IE recognizes the "site for the knower that is open to anyone" (D. E. Smith, 2005, p. 10). As such, in this inquiry focused on home care nursing, I began and carried out this research centred in the day-to-day experiences of home care nurses. As a part of home care work, nurses engage with clients, families, caregivers, other health care professionals who may see, experience, and carry out work differently. The nurses' standpoint was the place of entry and the focus for this inquiry, one that did "not subordinate the knowing subject to objectified forms of knowledge of society or political economy" (D. E. Smith, 2005, p. 10). Determining the standpoint involves identifying which knowledge will be recognized and who has legitimate knowledge is a question of power (Campbell & Rankin, 2017). Standpoints differ, as knowing is socially organized, and in IE power of who has legitimate knowledge is recognized, and the standpoint shifts the power to those in everyday experiences as the knower and expert (Campbell & Rankin, 2007).

An intentional focus on the everyday allows for the exploration of social relations and organization to discover what is readily visible to those doing the work, thus "expanding peoples' own knowledge rather than substituting the expert's knowledge for our own" (D. E.

Smith, 2005, p. 1). Taking up the social ontology and epistemological beliefs of IE results in an inquiry that starts in the standpoint of people's everyday experiences, exploring experiences such as the work of home care nurses to explicate how their work is occurring, which stands apart from beginning with a theory-governed discourse. Determining the standpoint provides the foundation from which to begin exploring data, as the standpoint determines whose knowledge is being examined, whose knowledge counts and will reveal different problems in the setting (Rankin, 2017). Identifying the standpoint determines a methodological stance and directs the researcher's focus (Rankin, 2017). As previously noted, this research, being from the standpoint of home care nurses, required identifying and tracing texts and discourse to determine how the ruling social relations coordinate home care nurses' work across sites, places of power and how the influences of capitalism and corporate functions influence the nurses' work. As such, I mapped work processes described by the nurses to identify common steps, processes and texts. From this mapping I was able to trace and identify policies that influenced these processes and how information generated by nurses in their practice was used by the health authority. This difference in understanding and use was revealed as I viewed the data from the perspective of nurses and how they described and saw the work they were doing carried out.

Ruling Relations

Ruling relations support the work of policymakers, managers, and administrators, whose interests may differ from those of the nurses and clients (Rankin & Campbell, 2006). As Rankin and Campbell (2006) noted, the text-mediated work of nurses often is in contradiction to the reality of their work with patients. Exploring the disjuncture between the actual work that is done and the managerial texts identifies the forms of power exercised over nurses and their work (Rankin & Campbell, 2006). Similarly, in this inquiry, the exploration of data entry in the

nurses' itinerary and multiple documentation systems revealed differences in the managerial uses of clients' information and the nurses' knowledge and work with the itinerary. The exploration of lines of influence and text-mediated control on practice is essential and reveals threads of ruling relations that expose larger discourses and power (Rankin & Campbell, 2006). Nurses hold a unique position in working with the realities of clients' experiences and lives and in working within the ruling relations of the health systems; this standpoint provides nurses with a valuable insight into the ruling relations that differs from those creating the ruling relations and different to those experiencing the effect of it (Rankin & Campbell, 2006). In exposing ruling relations, IE brings forward possibilities for transformation, showing participants and researchers ways of moving forward for change (Adams et al., 2015). In this inquiry, I explored how nurses navigated systems, procedures, and policies of the health authority while also attending to the needs of their clients; this created tensions for them, often requiring nurses to create workarounds to meet the needs of the system and their clients.

Implications for Institutional Ethnographic Inquiry

Entering into the Process

IE requires the researcher to enter into the process of inquiry with a focus on the work of the individual in the institution. Campbell and Gregor (2008) described the importance of entering into the site of inquiry without a theorized view of what is to be explored, but instead with a focus on people's experiences to see how external forces dominate their lives. The researcher enters with a theory of knowledge, but not a theory of what is occurring in the research setting (Campbell & Gregor, 2008). To begin IE, the researcher must take the standpoint of those who are being ruled, exploring their everyday experiences, the relations between their practices and people, mapping how things happen the way they do (Campbell &

Gregor, 2008). Entering with curiosity to explore and identify a problematic with an open inquiry process is the first step in IE (Campbell & Gregor, 2008). Researchers must remember that the goal is not to describe peoples' experiences but rather to reveal the processes that coordinate those experiences (DeVault, 2018). The focus must remain on the people's everyday experiences to uncover how these are coordinated and organized external to their control, thus aligning with IE's philosophical understandings and ontological position.

In this inquiry, the Level 1 participants were nurses working in home care in one health authority in Western Canada. As I approached this research, I took on a role as a naïve inquirer seeking the standpoint of home care nurses, looking to understand their work as a starting place for this inquiry. I collected data to first understand their work and then to look for places of rub and tension that revealed a problematic to explore further. My focus was situated in the nurses' work with the intention to highlight ruling relations, not to evaluate their work. I am an experienced community health nurse, but I do not have recent home care nursing experience. This provided me with an opportunity to develop relationships with participants in explaining that I do have experience in the community health context, which allowed me to maintain my questioning stance, as I am not familiar with the current language, processes, texts, and computer systems in the day-to-day lives of home care nurses.

The Problematic

The problematic in IE is an opening into the set of questions, or the puzzle to be explored, and is different from the research question (Campbell & Gregor, 2008). IE begins with people's everyday experiences; therefore, the problematic comes from the exploration with the people of what is going to be looked at (Campbell & Gregor, 2008). The stance of establishing a problematic from the initial collection of data differentiates IE from other forms of inquiry, as it

is not starting with a specific hypothesis to test or theory driving the question, but rather generating the inquiry from the everyday experiences of the people living and working in it (D. E. Smith, 2005). By identifying the problematic, the researcher can identify their stance and relationship to the inquiry (Campbell & Gregor, 2008). As previously noted, the problematic is not a specific question or problem, but rather the puzzle, something that is causing unease or concern in the setting from the perspective of the people (Campbell & Gregor, 2008). Grahame (1998) described the problematic as questioning of how things are organized, which then directs the inquiry to a domain of possible questions, beginning with the everyday world as it is lived. Unravelling the problematic as it exists and locating the connections and rubs that become visible in the exploration is part of determining the problematic (DeVault & McCoy, 2002).

Problematic is a methodological term in IE that "embodies and points to problems, tensions, and contradictions that arise in the relations between people and how society is organized … [and] is grounded in the social experiences that people encounter as troubling or difficult" (Bisaillon, 2012, p. 618). Campbell and Gregor (2008) suggested the problematic is identified after preliminary fieldwork and analysis with the people of interest in their everyday work. In this initial work, the researcher observes, takes notes, begins to write an account of what occurred, noticing the relations and taken-for-granted practice, questioning what is happening (Campbell & Gregor, 2008). The questions identified after listening and seeing the everyday work become the entry point into the inquiry. As such, I identified the problematic after my initial analysis of the tensions that nurses identified in their discussions about their work. Identifying the problematic was a critical step that helped me to retain a focus in the inquiry, as there were multiple questions and areas to explore. The problematic comes from data that reveal tensions or conflicts between what is seen as authorized knowledge and experiential knowledge

(Rankin, 2017). Identifying this place of rub, or disjuncture, is part of the initial data analysis process and leads to further focused data collection and analysis (Rankin, 2017).

D. E. Smith (2005) asserted identifying the problematic anchors the inquiry in the experience and opens the research to examine beyond what is happening locally to identify what institutional or social relations are coordinating the experience and the work. After reflection and analysis of the initial data, I noted several tensions in the nurses' work, and as I listened and reviewed texts, the morning work of creating an itinerary plan for the day emerged as an area for exploration as a problematic and focus for this inquiry. Each day, nurses complete an itinerary form, yet nurses identified different reasons for why and how they were completing the itinerary. These different reasons and lack of clarity led me to question how this one text is used: Why is there variation in its uses and purposes?

Language, Text, and Discourse

Language, text, and discourse are core elements of IE as they are instruments in and reveal how institutions are coordinated (D. E. Smith, 2005). Drawing on the works of Russian linguists, psychologists, and philosophers Herbert Mead, Bakhtin, Luria, and Volosinov, D. E. Smith (2005) identified a theory of language as a "medium in which thoughts, ideas, ideologies, and so on are lifted out of the regions of people's heads and into the social understood as the coordinating of people's doings" (p. 94). Language and professional discourse used in the sites of inquiry need to be noted and explored. For example, in Chapter 2, I identified the discourse of limited time and money and heard in the language nurses used, such as needing to triage and prioritize to ensure that their limited time was best used. Professionals have a particular language they use in their work; this language and its use reveal ruling relations (Campbell & Gregor, 2008). In IE, the researcher needs to clarify, ask questions, and explore the professional language

and discourses used to understand what is happening and not take up the language without understanding the underlying processes: "Professional language simply obscures what people actually do" (Campbell & Gregor, 2008, p. 72). The acronyms and process names used become common, taken-for-granted practices that drive the work and need to be understood. The types of language can come forward through all types of data collection, interviews, observation, text, and in both Level 1 and 2 data sources. Taking up the language of the institution[3] is a part of the ruling relations; for example, the language of efficiency is seen in several IE studies in which nurses become focused on the need to complete processes for efficiency based on the ruling text of the organization (Campbell & Rankin, 2017; Hamilton & Campbell, 2011). Remaining true to the value of text and discourse in the IE approach to research, language must be observed, collected, and analyzed.

As an observer in home care, I asked about the institutional language being used and ensured I understood its meaning, rather than assuming I knew what it meant and possibly missing out on important pieces of the ruling relations. As I do not have recent home health nursing experience, I was not familiar with the language, acronyms, or process terms used, and I needed to ask for clarification for my understanding. I often asked for abbreviations to be explained or terms to be defined so that I could understand more what the nurses were speaking about. The language used by nurses in talking about and observing their work was saturated with institutional influences. Terms such as triaging, collateral, and visit counts stood out as I collected and the reviewed data. Noting this language and highlighting terms were key in my

---

[3] Institutions do not refer to a specific place or location but rather are complex processes that coordinate people's activities across time and place (Bisaillon, 2012).

analysis of nurses' work, as language is culture because they show the codified and hidden aspects of the discourses and texts that enter unseen, in a taken-for-granted way, into the work of home care nurses.

Texts are central to IE inquiry. As D. E. Smith (as cited in DeVault, 2006) stated, increasingly technologies of social control are discursive and textual. Texts are written, spoken, or visual and can be replicated and, therefore read, heard, viewed by different people in different locations (D. E. Smith, 2005). Texts make connections to work, and through locating and analyzing texts, these connections, relations, power, and influences can be identified (Adams et al., 2015; Campbell & Gregor, 2008). Campbell and Gregor (2008) asserted, "Texts are relied on as crystallized social relations" (p. 79). Often texts are taken for granted and enter unseen into people's everyday lives. Once explicated, the analyst can see the ruling relations and how texts mediate actions across sites (Campbell & Gregor, 2008). The activation of texts, the process of taking it in, making meaning from it for ourselves, and then putting it into action is a dialogue, is ongoing, contextual, and affects how texts are utilized (D. E. Smith, 2005). In addition to seeing how texts are activated within the inquiry, researchers must also consider how they activate the texts in their interpretation and analysis (D. E. Smith, 2005). Texts such as those activated in home care nursing are more than the material documents; they are vehicles for taking up key discourses, instructing the reader in how to activate and use the discourses in the setting. It is this focus in a textual analysis that reveals the text's ruling relations and power (Rankin, 2017). In IE texts that mediate and communicate, the rules are collected and examined to explicate the ruling relations (Campbell & Gregor, 2008). In this research, the itinerary form is a text that guides everyday work of nurses. As Adams et al. (2015) identified, due to the setting that nurses work in

and its organization, dominant discourses in health care management, regulation, and biomedicine control the work nurses do.

Identifying texts and how they are used is essential, as texts make visible what is happening beyond the local setting into the trans-local social relations and illuminate the organization and control of the local site (D. E. Smith, 2006a). Texts should be analyzed in the sequence of how they are used and how they influence the work; they should not be analyzed in abstraction from their use (D. E. Smith, 2006a; D. E. Smith & Griffith, 2022). It is the use of texts and how they enter into a sequence of actions that show the ruling relations in a material form (Rankin, 2017; D. E. Smith & Griffith, 2022). In this inquiry, I collected texts and, more importantly, observed the texts being used to ensure I understood how they were activated in home care nurses' work rather than extracting and analyzing the texts as separate objects. The texts and text action sequences were key in revealing the linkages between sites of the work and influencing structures; I found the electronic health records and itinerary forms were utilized consistently, with varying understandings for why and how these texts were used by the nurses and the health authority.

Discourse is a term that has several definitions and uses. In a linguistic sense, discourse is "a continuous stretch of language containing more than one sentence" (Blackburn, 2016, p. 137). In this use, discourse could include discussions, conversations, narratives, and speeches. The term discourse is also used in constructionist theory to explain that meaning comes from how things and actions are represented in language (Hall, 1997). Foucault (as cited in Hall, 1997) argued, "Since we can only have a knowledge of things if they have a meaning, it is discourse—not the things in themselves—which produces knowledge" (p. 45). Discourse is centred around language, whether used to describe language and dialogue or how language is used to represent

knowledge and reveal meaning. Construction of meaning occurs within the discourse, and the meaning created within it influences history, culture, and power (Hall, 1997). Drawing on Foucault's work, D. E. Smith (2005) highlighted how discourse represents power and regulation and relates to the coordination of practices across sites. In IE, discourse differs from Foucault's use of the term, as it emphasizes that discourse originates in and exists only because of "people's participation in textually mediated social relations" (Bisaillon, 2012, p. 611). How people engage in discourse, talk about their work, the texts they use in their work, and how it is replicated are used in IE analysis (Bisaillon, 2012).

Work and Institutions

The concepts of work and institution are central in understanding IE as an approach to inquiry and identifying how this approach helps develop an understanding of home care. Work, as defined by D. E. Smith (2005), is more than paid employment and it is a "generous concept" (p. 151); the concept of work "extend[s] to anything done by people that takes time and effort, that they mean to do, that is done under definite conditions and with whatever means and tools, and that they may have to think about" (D. E. Smith, 2005, p. 152). In IE, work includes both the experience of the work being done (i.e., the what and how) and the implicit and explicit coordination of that work (D. E. Smith, 2005). The unseen and unpaid components of work are also included in the analysis and offer entry into understanding how the work is socially coordinated (D. E. Smith, 2005). For example, the work of waiting as identified by Diamond (as cited in D. E. Smith, 2005) and the work of feeding families in planning and thinking that DeVault (as cited in D. E. Smith, 2005) examined. It is the unseen work that often reveals the ruling relations of capitalism and control (D. E. Smith, 2005). The generous conception of work offers an essential view into nurses' work in home care, as it may include the unseen and often

unpaid thinking, coordinating, and reflective work of nurses. This view moves the inquiry from the objectified tasks that are often listed in competencies and job descriptions that can be seen by clients and counted in outcome measures to the work that nurses do in their socially coordinated work in home care. The focus on work as a broader concept is in contrast with what was identified in this inquiry as legitimized, counted, work by the health authority. This contrast will be explored further in Chapter 5.

As work is defined in a generous sense, so is the term institution. D. E. Smith (2005) identified institutions as "complexes of relations and hierarchical organizations that organize distinct functions" (p. 206), which can include health care, education, corporations, and others. Institutions are embedded in ruling relations, can appear to have local actions, and have standardized operations that generalize across settings, and operate within laws, government, professional and academic discourses (D. E. Smith, 2005). As Grahame (1998) explained, institutions are functional complexes generating forms of organization, creating abstract and generalizable accountabilities. The experience of individuals in the institutions is the entry point into the working of the institutions rather than "a case" (Grahame, 1998, p. 353). In IE, institutions are not equated to organizations; rather, institutions are coordinated work processes that can occur in multiple sites (DeVault & McCoy, 2002). Institutions are not the object of inquiry but are the points of connection, sites, and actions across sites (DeVault & McCoy, 2002). In this inquiry, in which I sought to understand home care, the entry was the everyday work of nurses in the institution of home care. Home care nursing offers a standpoint into identifying a problematic and tracing the social organization of home care relating to that view.

Data Collection and Analysis

Data collection planning can occur before entry into the site; however, establishing the standpoint and problematic occurs once connected to the participants, and the inquiry has begun. When approaching data collection, the standpoint of participants' everyday experiences is central; "the inquiry is always about how the subject's experience is organized" (Campbell & Gregor, 2008, p. 40). This orientation ensures the focus of data collection is on participants' experiences and locating data on how things are coordinated the way they are. While collecting data, the questions, what is recorded, and what is being looked for are different from traditional ethnographic data. The researcher must locate data to explain how things are coordinated the way they are in the local setting as well as the extra-local, outside the boundaries of everyday experiences (Campbell & Gregor, 2008).

Campbell and Gregor (2008) identified two levels of data collection for IE. Level 1 data are "about the local setting, the individuals that interact there, and their experience" (Campbell & Gregor, 2008, p. 60). Level 2 data are accounts that verify what was found in Level 1 and can explicate it, looking at the broader setting to see what connections can be made (Campbell & Gregor, 2008). Moving from Level 1 to 2 is an iterative process in the research setting in which verification and explication links to the data are found. However, Norstedt and Paulsen Breimo (2016) identified the challenges of locating the second-level data; selecting second-level sources and the contradiction of Level 1 and Level 2 data can create issues for the researcher. Level 2 data are necessary to ensure that the trans-local perspective is included and to note the places of disjuncture in which what is said from the two levels is noted for further explication (Campbell & Gregor, 2008).

Methods for data collection include those common to ethnographic research, such as interviews, observation, and text analysis; the methods used will vary depending on what is available and fits for the participants and locations (Campbell & Gregor, 2008). Interviews can be used at any stage of the research process, can be viewed as talking with participants, and do not need to be standardized, given that topics and who are interviewed will be identified as the research process unfolds (DeVault & McCoy, 2002). In order to be clear about what is happening, the interviewer will need to check understanding, clarify what is happening, and ask for specifics (Campbell & Gregor, 2008). In addition, the interviewer needs to be attentive and avoid taking up the common language used, asking for definition or clarity about meanings, and not filling in the blanks with what they think is occurring (Campbell & Gregor, 2008).

Experience is the central source of data and site of analysis in IE (Campbell, 1998). Collecting data on participants' everyday experiences, what is going on in the work-day-lives of home care nurses, then, is the primary interest of data collection processes. It has been contested that experience can be taken up as a "unitary" (Campbell, 1998, p. 56) representation; however, Campbell argued experience is a trustworthy unit of analysis. Entering into data collection with the intent to explore the everyday experience of the participants makes IE unique and focuses on the process of data collection from the view of the participants (Campbell, 1998). The common threads of data collection methods relating to observation focus on participants' experiences, questioning and tracing the organizing features and local as well as trans-local coordination, resulting in something akin to a map. For this inquiry, from the standpoint of home care nurses, I entered the map and began primary data collection using interviews and observations as well as collecting texts with home care nurses. I identified second-level participants (including nurse leaders and managers who have supervisory and support relationships with home care nurses but

are not providing direct client care) and met with them to collect data through interviews. These processes are described in further detail in the "Ethics" section of this chapter.

In IE, the researcher gathers and analyzes data to identify the social relations present in the problematic. Analysis and presentation of the findings are focused on highlighting the connections found in the data and articulating the implications for others (Campbell & Gregor, 2008). In completing this analysis, the researcher does not code, theme, interpret, or break down the data, but rather remains true to IE's focus in identifying what is happening in the setting and showing the social relations are in these instances (Campbell & Gregor, 2008). The researcher must aim to explicate the social relations, "identifying, tracing, and describing the social relations that extend beyond the boundaries of any one informant's experiences" (Campbell & Gregor, 2008, p. 90). The process of explication aims to identify what is coordinating the work beyond the local setting (Campbell & Gregor, 2008). The analysis shifts the focus from what is done to mapping the relations and connections to illuminate coordinating features. Looking in the data for the direct and indirect references to institutional practices and language and engaging with the data and language to identify and trace the institutional relations is key for analysis in IE (Rankin, 2017).

Data Collection and Analysis Process for this Research Work

Context

This research connects to a larger home care research project aiming to inform the development of promising practices for equitable and consistent access to home care in Canada (Stajduhar & Contandriopoulos, 2018). The objectives of the Tackling the Home Care Challenge (THCC) project are to examine the service delivery models of home care, describe structural and operational processes of home care delivery models, provide a detailed contextual description of

home care practices in three Canadian provinces, and explore how everyday practices in home care may contribute to disparities between and within provinces (Stajduhar & Contandriopoulos, 2018). Using a mixed-methods approach, the research team has completed a realist literature review (Stajduhar & Contandriopoulos, 2018) and is near completion of an IE in home care. I was a doctoral research assistant on the THCC project, and the data utilized in this dissertation is drawn from the larger study.

This research took place during the COVID-19 pandemic. The context of the pandemic had impacts on data collection and on the opportunities for action as discussed in Chapter 7. While the pandemic impacted this research it also had impacts on the nurses work. References to working from home, assessing and screening clients via telephone, and pandemic restrictions are included in the accounts of nurses work.

Entering into data collection for the larger project, I maintained an interest in hearing from the nurse participants about their work and the social organization of it. During data collection, I identified several tensions and contradictions in nurses work; for the purpose of my dissertation, I focused on nurses' itineraries and how the work they do each day to coordinate, plan, report, and record their work is connected to and influenced by organization power, influences, and coordination outside their view. In the research project, I connected with nurses who worked in four different locations, three health units in a mid-sized city and one health unit in a smaller community. All works sites were within one health region in Western Canada and were engaged in the THCC project. Although the settings are unique because of the size and geography of the communities and the number of staff working in the health units, the governance is similar. This also enabled ethnographic access and the tracing of ruling relations to identify trans-local organization, policies, and practices that coordinate across different sites and

communities. The nursing program within home care is publicly funded. However, medical supplies and equipment such as dressing for wound care or walkers are a combination of publicly or self-funded, and there are differences in what is publicly funded for home support services and what home support services requires clients to pay for services or equipment. For example, clients receiving home support services to assist with dressing and medications in the morning are charged a fee based on their income; however, if clients are receiving palliative care benefits, then they do not pay for home support services.

Ethics

I adhered to the core principles of the *Tri-Council Policy Statement* for conducting research involving people: respect for persons, concern for welfare, and justice (Canadian Institutes of Health Research et al., 2018). As this inquiry was connected to the larger THCC research project, I followed the ethics protocol approved for that project. Ethics approval for the project was obtained from the research ethics review board through the harmonized process with the University of Victoria and Island Health Authority (Appendix A).

Informed consent for participation was confirmed using the THCC processes, forms, and protocol. Consent for the nurse participants was obtained using the THCC consent for observation (Appendix B) and THCC consent for interviews (Appendix C). Nurses who were interested in participating received an email and the consent forms from the THCC research coordinator. The coordinator followed up with each potential participant to review the consent, address any questions they had, and the coordinator received the completed consent forms for tracking and storage. I established processes to gain consent from clients if the nurse’s work I observed included client care; however, due to restrictions with COVID-19, I was not able to observe nurses working with clients, and these consent processes were not utilized. Consent to

participate in the study was voluntary and could be revoked at any time, removing the participant from the research process; however, this did not occur during this study, as all participants who provided consent continued through the research process. Consent was documented on the THCC forms and stored securely with the THCC research coordinator. Each time I connected with a participant, I confirmed consent. For interviews, I asked each participant to confirm that they had provided consent and asked if they had any questions before we started the interview. In advance of meeting each participant for observations, I connected with the participants virtually over Zoom and reviewed the consent they had provided, discussed where to meet and when, reviewed the purpose of the study and observations, informed them I was there to learn about their work not assess or pass judgment, and asked if they had questions. During the observation period, each time I met participants, I asked if they were fine with me coming today and continuing with the observations of their work.

Throughout data collection and recording of data, I ensured the anonymity of participants in my data management. To address privacy and confidentiality, I used anonymous labels when creating research notes and transcriptions. Each participant received a number for the THCC study, and a label (HCN 1, HCN 2, etc.) to sort participant data. The THCC Research Coordinator kept a list of the labels and corresponding identifiers for participants in a Microsoft Excel sheet on a secure site at the university. I maintained a list of the participant codes that I was using with only non-identifying information on the list. As per the THCC approval ethics protocol, the key code linking participants to the data will be destroyed 1 year after the completion of the research, and all data will be destroyed 5 years after the project is completed. Interviews were recorded and transcribed, the recordings of the interviews will be kept until the research results are written and disseminated; recordings have been saved with anonymous labels

and are stored on the THCC secure site. I ensured participants anonymity when writing the results of the study and for dissemination purposes by using pseudonyms for both their names and places of work (e.g., Health Site 1, Health Site 2, etc.). Secondary participants' titles and the site names where they work have been eliminated from the description of participants to ensure that they are not identifiable.

Due to the COVID-19 pandemic, additional safety measures were in place to ensure the safety of participants as well as my own safety as a researcher. I followed the Island Health and University of Victoria COVID-19 research resumption plans as detailed in the THCC study protocols, which included the use of remote technology to access and engage with participants and the use of personal protective equipment as per Island Health policy for onsite observations within health authority sites. I conducted all initial planning conversations for observations as well as interviews over Zoom, rather than in person. Observations were delayed for several months as the resumption plans did not allow for in-person research observations. Once the health authority and university allowed for observations to occur, the revised plans allowed researchers to observe nurses in their work sites only. I was not permitted to travel in a vehicle with the participants or to go with them to client homes. With these COVID-19 restrictions in place, I was able to observe nurses in their office work only. In addition, I needed to complete daily health screening to test if I had symptoms, refrain from entering the sites if I had any symptoms, and wear a mask during all onsite observations.

Participants

Two groups of participants were involved in this research, nurses who carry out the everyday work in home care and second-level participants in leadership roles in home care programs. To recruit the nurse participants, I used convenience sampling; I offered interested

parties who came forward the opportunity to take part in the research. Following data collection and analysis with the nurse participants involved in direct care, I identified potential second-level participants, who were purposely selected. I reached out to the second-level participants directly by email and invited them to contact me if they were interested in taking part in the research.

I recruited nurse participants by sharing study infographic and recruitment information posters (Appendix D) through email coordinated and sent through the home care leadership team for the selected sites. I also attended home care nursing team meetings with the THCC research Principal Investigator and Research Coordinator to share information about the study and answer questions. If nurses were interested, they contacted the THCC Research Coordinator, who provided them with the study information and consent forms.

As with other qualitative research approaches, no set number of participants could be identified at the outset of the inquiry (Creswell & Creswell, 2018). In IE, "emphasis is instead placed on features of experience, diversity, and social location" (Bisaillon & Rankin, 2013, p. 5). The goal of data collection and analysis in IE is "to make visible the ways the institutional order creates the conditions of individual experience" (McCoy, 2006, p. 109). With this understanding, the number of participants ($N = 13$) engaged in the inquiry was determined by the capacity to map the social relations, rather than ensuring a collection of complete perspectives on their individual experiences. With the initial 10 primary participants, I was able to map and see linkages in their work. From there, I moved to second-level participants and textual data to link and describe the coordination of the nurses' work. Participants in the study had different levels of experience as nurses and in home care with the majority being early and midcareer nurses, were located in three different health unit locations, and had diversity in age and gender (see Tables 1 to 5 for participant demographic data).

Table 1

Participant Gender– Primary and Secondary

Gender	No. of Participants
Identify as female	10
Identify as male	3

Note. N = 13.

Table 2

Participant Age – Primary and Secondary

Age in Years	No. of Participants
20–29	3
30–39	6
40–49	3
50–59	1

Note. N = 13.

Table 3

Participant Nursing Designation – Primary and Secondary

Nursing Designation	No. of Participants
Registered nurse	10
Licensed practical nurse	3

Note. N = 13.

Table 4

Participant Years of Work in Home Care – Primary and Secondary

Years of Work	No. of Participants
Less than 1	1
1–4	4
5–9	5
10–14	2

Note. N = 13.

Table 5

Participant Years in Nursing Practice – Primary and Secondary

Years of Work	No. of Participants
Less than 1	1
1–4	4
5–9	5
10–14	2
15–19	0
20+	1

Note. N = 13.

Primary Participants. Nurses working in home care who consented to participate in the THCC project were the primary Level-1 participants, for my inquiry. Participants included a licensed practical nurse and registered nurses who carry out work in home care (see Table 3). Participants' experience in home care ranged from less than 1 year to 14 years of experience (see Table 4), and participants' experience in nursing ranged from less than 1 year to more than 20 years (see Table 5).

Secondary Participants. As I collected data with the primary participants, I asked about who else I should meet and interview and listened for links to whom the primary participants identified as their connections, from where their guidance and direction were coming from, and who else I might need to speak to in order to understand the work and coordination of it. Second-level participants included individuals in formal leadership positions, including nurse managers and clinical leads. All three second-level participants identified as registered nurses; their roles and titles varied, but they offered insight into the ruling relations emerging from the inquiry.

Access and Site of Research

Entering into the site of the inquiry as a researcher and developing trust are critical steps in the research process (Polit & Beck, 2016). As an experienced community health nurse, I understood the importance of relationships and trust and was aware that there may be questions and curiosity about what I was there to do and why. I was aware that there could be a perception of me being there to evaluate or pass judgment on the work; however, this did not emerge as an issue. To build trust with the participants I was interviewing, I met them on the Zoom platform and introduced myself, reviewed a standard introduction to the project confirming their consent and asked for any questions they had. To establish a relationship and trust with the participants that I was observing, I met with them ahead of my arrival on Zoom to introduce myself, reviewed the research project, address questions they had, and arranged our plan for meeting and starting observations. The first time I was observing onsite, I arrived, and the participant toured me through the building and introduced me to people as we met them; this included the leadership team and many nurses. The staff started to recognize me on subsequent visits, and fewer introductions were needed. Each time I was onsite for observations, I posted an infographic (Appendix D) by the staff sign-in sheets to let people know I was at the health unit

observing for the study and to provide some information about the study. As I was introduced to the staff, they often asked what I was there to research and how long I would be there. I talked about the study purpose and answered any questions they had; often, they would indicate interest in the work and shared comments about some of the issues and concerns. Several participants as well as other nurses in the health units had worked on previous research projects with the Principal Investigator for the THCC study, and when I mentioned that researcher, they were often keen to share their experiences in their previous work with them and identified support for the work. Often the comments received were that they were grateful to have someone looking into their questions and issues.

Data Collection Methods and Context

Consistent with data collection procedures for the THCC study, I utilized three data collection methods: interviews, observations, and text collection. While some of the data were collected by team members of the primary study, I was also intimately involved in the data collection process as a doctoral research assistant for this project. Data collection occurred over 9 months, from March 2020 to December 2021 (see Figure 1). During this time, the COVID-19 pandemic was occurring, which impacted data collection timing and approaches. Originally, I had planned to complete observations with participants first and then follow up in person with interviews. However, with the changes to health and safety requirements, I completed virtual interviews using the Zoom platform first with the participants followed by observations in person. Observations were delayed based on institutional processes for health and safety from both the University of Victoria and the health authority, in line with the Provincial Health Officer’s orders, and were limited to in office observations only, as it was deemed to be unsafe for researchers to travel in a vehicle with nurses or enter homes of clients. Additionally, the

home care offices started using an electronic documentation system in the spring of 2020 as the pandemic began. This shift in documentation impacted data collection as some materials are online and some are in paper. These contextual influences for data collection also affect nurses' work, which will be addressed in the description of work in Chapter 4.

Figure 1

Data Collection Timeline

	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Gaining entry recruitment & consent											
First participants (HCN)											
Semi-structured interviews (*n* = 9)											
Observations (*n* = 6) In person											
Secondary Participants											
Semi-structured interviews (*n* = 3)											
Collection of texts											
Analysis											

Note. HCN = Home care nurse.

Interviews. I started my data collection using semi-structured interviews virtually using the Zoom platform. For the interviews, I utilized an interview guide developed with the THCC team (Appendix E – Level 1 Interview Guide). The questions and probes provided suggestions and some structure to the conversation to ensure a consistent approach when I asked about the work and a typical day for the nurses. The guide also ensured that the focus remained on nurses' work and the standpoint of the nurses engaged in their work. To begin each interview, I asked the participants to talk about and describe their work within home care. I then asked them to

provide an example of a client encounter and I guided the conversation asking them to walk through each step of their daily work. For example, I asked questions such as the following:

- How do you know that you needed to see this client today?
- How do you prepare for your visit?
- When you are going to the home, can you please talk through the steps you take?
- When you are finished with your visit, what do you do?

As we talked in the interviews, I kept notes to highlight pieces to return to after the participants had walked through their examples such as questions or processes that I needed further explanations for. For example, in one interview a nurse was telling me about her work preparing for the visit, collecting the documentation and collateral. I am not familiar with the term collateral, so after she finished explaining her process I asked what collateral is. During the interviews, I utilized the interview guide questions but also balanced this with listening and focusing on what was being said so that I could ask for clarification on terms and language used, processes and forms that were referred to, and prompting to ask about what is next and what steps led from this piece to the next. Several times the participants would say, “You are a nurse, right, so you know what that is.” In response, I asked for clarification and either shared that I was not familiar with the term or asked them to explain further as others might be reading that transcript who are not nurses. This encouraged them to use more plain language and explain their processes in greater detail.

With the consent of the participants, I recorded each of the interviews on Zoom and ensured the audio portion was saved and transcribed. As G. W. Smith et al. (2006) identified,

> [Tape recording and transcribing interviews] is essential to be able to develop detailed and systematic interpretations of the data. Making interpretations as a part of in situ note-

> taking makes it more difficult later on to explicate the social organization of the relations in which informants' descriptions are embedded. (p. 174)

The process of recording the interviews helped me to listen in the moment and then later to re-listen to pick up cues about the texts, coordinating features, and rubs. Each of the home care nursing interviews ranged from 60–90 minutes in length. Six of the nursing interviews were with nurses in one of the larger city's health units, three of the nurses interviewed worked in a health unit in the smaller community, and the tenth nurse participant was a nurse in the larger office who participated in observations only. During my observation with the nurse who did not complete an interview I was able to ask questions and clarify as we went through the observation days together.

After initial data analysis, I prepared questions and sought out the second-level participants for semi-structured interviews. The second-level participants all identified as registered nurses who work in different formal leadership positions within home care. These interviews ranged from 60-90 minutes in length. Similar to the home care nursing interviews, with the consent of the participants, I recorded the interviews on Zoom, and ensured the audio portion was saved and transcribed. I developed an interview guide to focus my conversation with the second-level participants and in a similar way to the primary interviews, asking about their work and for descriptions of a typical day in their role (Appendix F– Level 2 Interview Guide). During the interview conversations, I noted relevant texts and language being used and asked to follow up on procuring the texts and clarifying the language used. I also asked specific questions to clarify policies and procedures that informed their work and decisions that they were discussing.

Observations. I observed three home care nurses in their work at their health units and accessed data from three additional observations of home care nurses' work. All of the observations were 2 to 3 days in length and focused on observing the nurses' work in the office setting, as I could not travel with them or attend visits in homes due to COVID-19 restrictions. The nurses I observed worked day shifts and were in different types of employment roles, both casual and float. One of the nurses I observed typically worked as the float nurse on afternoons and evenings, but was temporarily working day shifts during the time I was observing. I completed 30 hours of observation with home care nurses and accessed the data from colleagues who observed for 50 hours with home care nurses in different health unit locations.

These observations allowed me to listen, see, and learn what the nurses do and how they carry out their day-to-day work in home care. Balcom et al. (2021) identified observations in IE help create the contextual picture for the data collected through interviews and text and confirmed what was shared in interviews occurs in practice. Additionally, observations can help the researcher ensure that rhetoric or oversimplification of processes that can occur in interviews is counteracted by seeing these actions in process (Balcom et al., 2021). For example, in interviews, nurses described the process of intake, pulling the information together to learn about the client; during observations, I was able to see the many steps this takes. During observations, I had conversations with the nurse participants to clarify what I was hearing or observing, asked for further information on the language used, and sought out documents to determine what was guiding the work. DeVault and McCoy (2002) identified talking with participants as a form of an interview. These interviews or conversations occurred naturally in a time that did not impact the nurse's work, attempting to be as least intrusive as possible.

I documented the observations using free-form narrative note-taking, focusing on what work occurred, what documents were used, the language used that stood out, and questions that emerged from my observations. During the observations, I recorded information in a small notebook that was not obvious to the participant to reduce the feeling that I was making notes on them. I also talked with the nurses ahead of the observations and on the day of to explain my process for watching, listening, and taking notes to help ease the sense of being surveilled. To prepare each day, I reviewed a template created with the THCC team to structure notes for observations. The template (Appendix G – Observation Guide) outlined questions and ideas to focus on for the observations.

On the first observation day, I focused on the setting to get acquainted with the space and people and the flow of the work. In the subsequent observation days, I focused on observing the work of nurses, noting texts used, the flow and organization of their work, and the interactions they were involved in. I followed each participant as they worked; if it was appropriate to ask questions, I would ask about a text or task to clarify or understand what was being done. I collected the texts nurses used while I was observing them, ensuring there were no client identifiers on them. As Balcom et al. (2021) identified, observations in IE differ in the focus and orientation from observations in traditional ethnographies; observation of data in IE is focused on learning how texts are activated to fill in steps in processes that may be identified but not fully described in interviews. Observations can confirm and fill in data from what was being collected (Balcom et al., 2021). I found this to be true, as the interview data collected was so rich in description the first few days of observing. I was able to see what the nurses described, confirm the information they had shared, see the use of the texts and documents they had described, and understand from the nurse’s view how these pieces were taken up and used.

After each observation day, I took notes to capture the day's workflow. I then used these notes to summarize each observation day in chronological order, from the start of my observation to the time I left. Once the chronological write-up was complete, I saved this to a password-protected flash drive with pseudonyms for the participants. As I typed the notes and reflected on my time with the nurses, questions and thoughts came up for me, I added these to comments to the chronological summary document. I also highlighted questions that came to me in the review of the notes to ask the nurses on my next observation visit with them. Colleagues in the THCC research team completed three of the observations I included in this research. They also created free-form observation notes from their time with the nurses. These observations were also 2 to 3 days in length, focused in the office setting, and guided by the THCC observation guide.

Texts. Participants referred to many documents, forms, and charts in both the interviews and observations, and these were used directly in their work and referenced as policy or guiding documents. I was able to collect copies of texts during my observation time. I also requested and received copies of texts from a health unit administrative support person identified as a contact for the THCC research team (see Table 6 – Texts Collected). The challenge was determining which texts to gather for analysis. Given that the analysis of texts is intended to focus on how the texts are used, the text-action sequence, and how they coordinate work, rather than an analysis separate from action or activation, as might be done in discourse analysis, I was able to limit the texts collected. With this understanding, I focused my collection on texts used in the work that fit within the problematic and referred to by the participants or observed in use. After preliminary review and initial analysis, I identified additional texts mentioned as being linked to the work or influencing the work by participants and procured copies of those.

Table 6

Texts Collected

Texts Used in Nurses' Work	Texts from Health Authority or Government
Daily Employee Itinerary Check-in	Home and Community Care Minimum Reporting Requirements Visit Definition (Ministry of Health)
Documenting a Staff Safety and Awareness Plan	Health Authority Health Performance measures Home Care Professional Services
Assigned and Delegated Task Grid – A general guide	Health Authority – Health Service Plans
Community Health Services Client Services Agreement	Work Safe BC – Occupational Health and Safety Regulations and Guidelines Working Alone or in Isolation
CHS Single Client Record Prototype	Ministry of Health – Home and Community Care Policy Manual
CHS Clinician Documentation at a Glance	
Quick reference guides for PowerChart	

Note. CHS = Community Health Services.

An additional challenge of collecting texts in this setting was the increasing use of electronic texts. Collecting electronic documents poses unique challenges, as access to them is limited, and the ability to take screenshots or samples of the texts is not possible when client identifiers are visible on the screens. To address these issues, I asked nurses to describe their use of the electronic systems in their interviews, and, during observations, I was able to see the systems in use and make notes about how the electronic systems were used. I obtained copies of quick reference guides that included directions on how to use portions of the electronic record and screenshots of the pages used. These guides provide directions to providers on how to use the system for documentation. The collection of electronic texts is a challenging aspect of data collection in IE. However, given the focus on text-action sequence, I was able to develop an

understanding of the texts and their use when physical copies of the text were not available. In data collection, I was able to mitigate not having a copy by observing the use of the text, taking notes of the text as I saw it being used, and probing the nurses on how they were using the texts in the interviews.

From the three approaches to data collection, I generated an observation notebook (from field observations), observation notes (electronic), interview recordings, and transcripts, texts, and reflective notes. I also created maps of work processes as I started to think about the data and analyze it; examples of the maps are shared in Chapter 4. I stored these materials securely with non-identifying participant labels either on paper records (i.e., notebooks) kept in a locked filing cabinet or on my password-protected flash drive (i.e., maps and transcripts).

Reflexivity

Reflexivity in qualitative research is a process of reflection on the part of the researcher identifying their role in the study and the potential to shape or influence the direction and interpretations of the study based on culture, experiences, and background (Creswell & Creswell, 2018; Polit & Beck, 2016). This process went from recognizing my biases and values to considering how who I am and how I saw the work would influence the outcomes of the inquiry process (Allen, 2015; Creswell & Creswell, 2018). In seeking to carry this inquiry "from inside the social organization of not only our own world as researchers but, by extension, the social worlds we intend to investigate" (G. W. Smith et al., 2006, p. 173), I needed to reflect on the potential influence of who I am, as an outsider to home care, as an academic, on the data analysis process. I made notes of my questions and reactions to situations through the data collection and analysis processes to assist with this awareness and reflection. I reviewed these comments and

notes as I entered into analysis to see how I noticed rubs, tensions, language, and gaps, and how this changed as I progressed in my research process.

One day, I noted how the health unit building itself was locked, with limited access to staff with keys; it was not part of my data on the nurses' work, but rather a reaction and concern I felt as I entered into the building. It was important to note this and consider how it impacted my perception of the site. I wrote reflective notes and kept them as a part of the data collection analysis process in a small notebook for myself. These notes included reflections on my process (interviews and what to work on next time) as well as on the content of the interviews or observations. For example, after one of my first interviews, I noted,

> Interesting how safety came forward as a concern—she teared up while we were talking about her example. She had a nice way of describing the aesthetic way of being, parts of practice—what you can come to know/learn in the home. I have a question about workload and volume/assigning clients—how many.

After a subsequent interview, I wrote a note for myself about the interview process: "She had a strong focus on her work and the client, it was a challenge to tease out what her work is, not the client focused work." I also used my notes to track my thinking or initial reactions. For example,

> They wanted to tell me their stories—asked to share, it seems like this is one way for nurses to have a voice, to participate in research. "What is nursing work" stood out as a question when I reviewed my observation notes today—coordination, scheduling, communication, patient care, gathering supplies, updating care plans, referrals all stand out.

This reflective journal was a place to note my thinking and questions, and reviewing these helped me to see how this developed throughout the inquiry.

As Walby (2007) explained, the researcher maintains significant authority over how data will be represented. He challenged IE researchers to consider the role they have in representing accounts, interpreting transcriptions, and creating rather than preserving the subject (Walby, 2007). It was critical that I acknowledge and attend to the role I had in interpreting the transcripts, picking institutional accounts, and reassembling the data (Walby, 2013), as those actions shaped the account of the inquiry. I aimed to start from the experiences of the everyday work of home care nursing and return to these, centring my collection processes and analysis on the details and subjectivities of everyday work was a way of ensuring that the accounts represented the standpoint of participants. What becomes generalizable from the interpretation of the nurses' experiences is the map of social relations from these work experiences, rather than the individual accounts (Walby, 2013).

To help with my reflections on the data, I made notes on transcripts and the observation summaries. I added comments to the transcripts and the narrative summaries of the observations, identifying questions, pieces for follow up and clarification, and my wonderings that emerged through the data collection process. These notations helped me to see my reactions and question processes while assisting with my reflection on the data and what I was noticing. Additionally, the THCC research team met to discuss mapping, lines of inquiry, as well as threads that had emerged for the larger study questions; these discussions were part of my reflection on the data. I also met with my dissertation committee to share my thoughts and questions about the data, my experiences collecting it, and my analysis process as it unfolded. The committee provided feedback and direction as I progressed through data collection and analysis that was a part of my reflective practice.

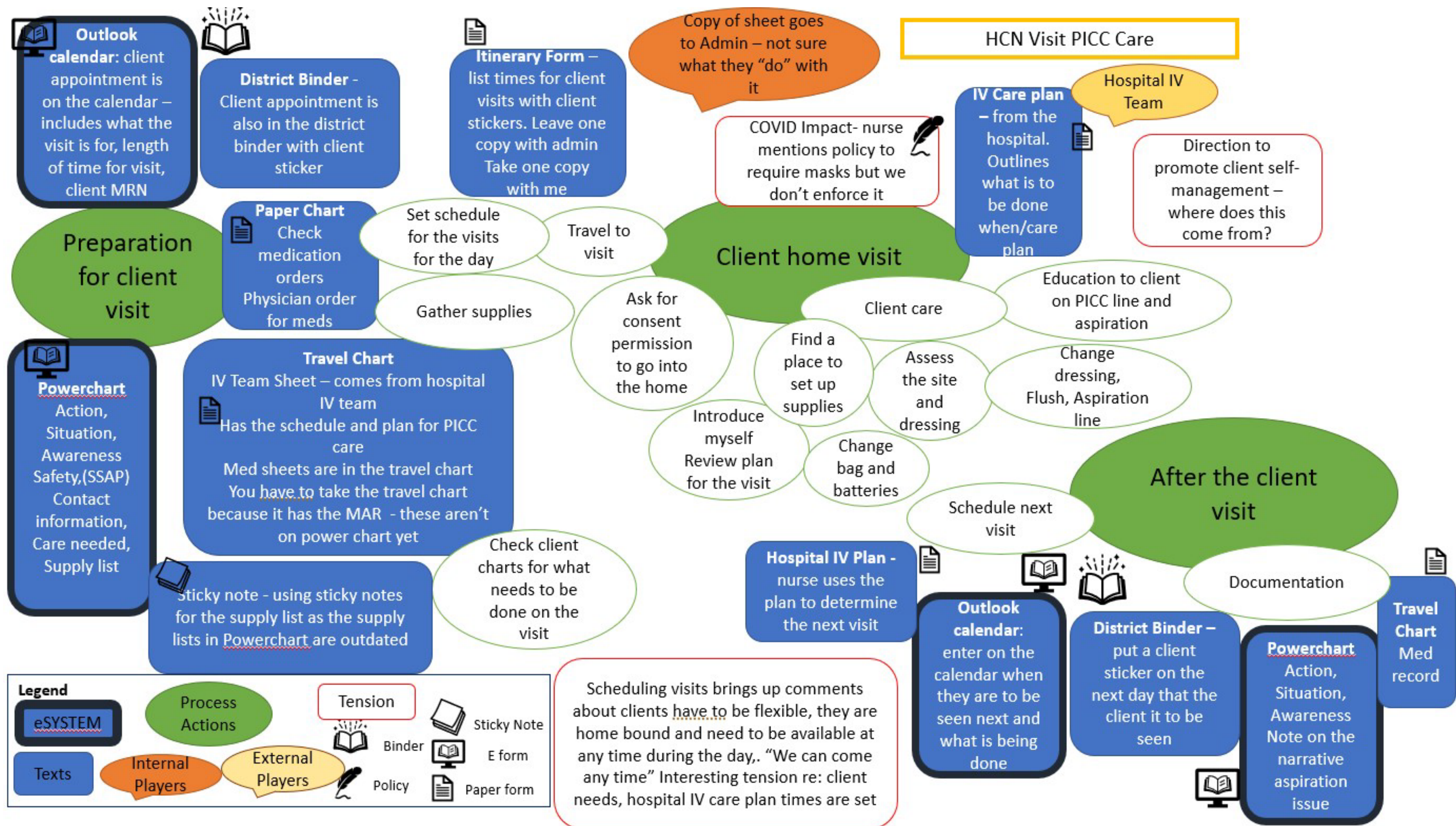
Analysis

Data analysis in IE is an iterative process (Rankin, 2017). In my inquiry, the analysis occurred over time as I read through transcripts, re-read transcripts, sought out and reviewed texts, and made observations notes and reviewed them. I continued to move into the data to read and question, and then back to collect further data for review and analysis again. To begin the analytic process, I initially mapped out the work processes of the nurses from the interviews and transcripts I had created or gathered. Through the process of listening, reading and re-reading, I created visual representations of the work processes and texts the nurses identified in their interviews.

From these interview transcripts, I also noted places of tension, where what is known and talked about in the discourse was different from the everyday experience, in order to help identify the problematic for this inquiry. These first maps helped me understand the work the nurses were doing and identify language and texts that they commonly spoke of, and helped me identify potential problematics to explore further. Mapping is a visual depiction of the connections between text and action, creating links from one to another, illustrating the flow and connections of work to the institution's influences (Turner, 2006).

Figure 2

Map of Home Care Nurse Visit



Text analysis and mapping the worktext sequence are central analytic processes in IE (Turner, 2006). Mapping texts and work reveals the capacity of texts to produce and organize activities (Turner, 2006). When mapping, I created a sequence of the actions as the nurses described their work from the start to end and included icons to show electronic texts, charts, paper texts, documents, and where they were used in the work process. I also colour coded the activities to show how their work linked to other people within the organization and external to their organization. These visuals helped to show the flow of work and the texts used as well as policy influences and places of rub. The Map of Home Care Nurse Visit in Figure 2 is an example of the maps I created as a part of my initial reflection on the data. As the nurses talked about their work, I grouped their activities into three categories (preparing for the visit, client home visit, and after the client visit), as shown in Figure 2 as green circles. In the blue squares I identified the texts and etexts that nurses used to complete their activities. The nursing processes they completed in each activity are indicated on Figure 2 in green, including setting schedules, collecting supplies, contacting the client, assessing, providing care, and documentation. The mapping highlights the cycle of work that occurs over the day for each client, the information systems and tools used, the contact with clients, and the follow-up care that is provided. As I drew out the maps, the statements nurses made stood out as tensions, and I noted these on the maps in red boxes; questions or issues raised by nurses fit into their descriptions of their day.

In addition to mapping, I used several other strategies to assist in making sense of the data collected; Rankin (2017) highlighted that multiple approaches are needed in the analysis process to become familiar with the language and begin to trace ruling relations. I reviewed each transcript multiple times, highlighting language, texts, and tensions in different colours, adding notes and questions on the side of the transcripts with comments (see Figure 3).

Figure 3

Analysis of Transcripts

68 I: Okay, so I am going to go back to managing those terms of carrying a caseload, what does that mean?¶

69 P: Yeah, um so carrying a caseload means that, you know when somebody is referred to Home &
70 Community Care there is a file opened for them and they are assigned, you know if it is an Occupational
71 Therapist or if it is a nurse they are assigned a specific person and so they you know they are inputted
72 into that persons calendar and that is kind of the main point of contact for that patient. So you know it
73 is, that nurse will make sure that we are seeing them on a frequent basis, but then I think that what gets
74 very difficult about that is that we have so many clients who are on with home support workers so they
75 are getting assistance bathing, or with meals or with medical needs and so if any of our Home &
76 Community Care care aids have; we call them CHW's so I'll just start using the term CHW, so if a CHW
77 notices anything they report it to us so it can be something like someone had diarrhea, someone has a
78 red area below their knees, so you can get up to 30 e-mails a day as a district nurse and you know in
79 most of my days I don't have time for anything else than what I was assigned at the start of the day if
80 that. So when you look at having these spontaneous e-mails coming up; and a lot of them as you get to
81 know your case load better you'll know oh you know John Doe is a diabetic, his leg opens and closes,
82 opens and closes, I can get to this in two days, um or this sounds more emergent, but you constantly
83 have to triage these complaints. And sometimes they amount to nothing, you know other times, you get
84 oh a red bum, you go in it is nothing and other times you are like how did this pressure sore get missed
85 for so long. So you are kind of responsible for responding to all of those concerns. ¶

86 I: Okay so caseload would be then a nurse is assigned as the person to setup sort of 80 or plus clients, so

Microsoft Office User
Language – carrying a case load
Reply

Microsoft Office User
Process – assigning clients
Reply

Microsoft Office User
Tension – Time, communication with CHW's
District nurses receiving reports from CHW's
about client concerns – so many emails that "I
Reply

Microsoft Office User
Tension – time management – constant complaints
Reply

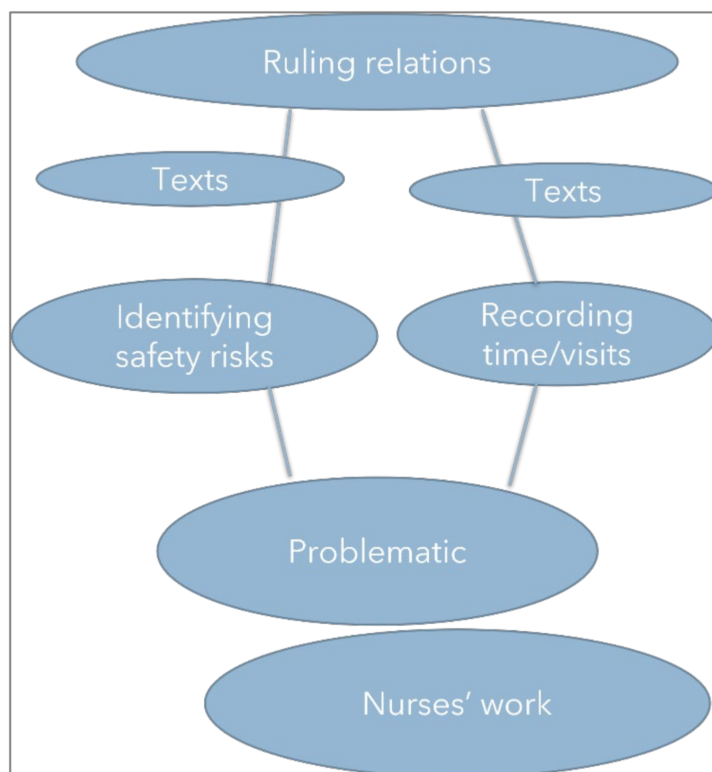
Reviewing the transcripts and highlighting institutional language and terms, I identified and developed a "sensitivity" (Rankin, 2017, p. 4) to the institutional language. Identifying the language was an important first step, as it helped me see and hear traces of the social organization (Rankin, 2017). As well as reviewing transcripts, I read through observations notes, both my own and those from team members in the THCC study who contributed the observation data. From the review of the observation notes, I kept a Microsoft Word document and copied and pasted in accounts from the observation notes that identified texts and ruling institutional practices. In this document, I highlighted institutional language and added noted identifying questions that came up for me as I read and re-read the transcripts.

From this orientation into the data, I indexed and began to draw out how the accounts linked together, traced the work and texts, and identified what people who are located differently do in the institution (Rankin, 2017). To do this, I reviewed the transcripts and observation notes,

pulled examples from nurses' descriptions of their work, and copied those into a running Microsoft Word document of accounts. I started to see linkages and gaps in the accounts nurses shared of their work to subsequent processes, texts, and institutional rules. For example, nurses used similar words and phrases such as priority, rationing, and rules for time allotments when they talked about scheduling client visits, setting priorities, and informing clients about their visit times. Indexing, which is a process to identify linkages between the work and what is organizing it (Rankin, 2017), can help avoid theming data. I found indexing helped me focus on the material linkages of the coordination of work activities (Rankin, 2017). Following this, I began to note ideas about ruling relations and traces of how work is organized, noting questions and following up to find texts or accounts that materialized the links and steps to the broader coordinating features (see Figure 4). These accounts and my notes and questions began to show the links between the use of itinerary and the larger trans-local coordination of the work of nurses.

Figure 4

Process of Moving from Work to Ruling Relations



I also identified accounts in the data that explicated the ruling relations. Campbell and Gregor (2008) suggested researchers find an account from the data that illustrates relations and connections and then map and trace these to help with their entry into the analysis process. Written or analytic accounts, as Rankin (2017) identified, could help describe the work and institutional processes they are drafted from and link back to the work of the nurses and the challenges that emerged. I utilized the accounts to identify stories from the nurses that highlighted influences of ruling relations in their work; this approach in my analysis process helped me focus on the location of the nurses' everyday experiences in home health nursing practice.

The central unit of analysis in IE is the social (G. W. Smith et al., 2006), and the focus must remain focussed from the standpoint of the nurses. The analytic interest is in discovering

how the discourses are operating in the nurses' work (McCoy, 2006). To maintain these foci, I used the problematic to guide my analysis. Additionally, centring my analysis in the rich descriptions that the nurses provided of their work and the observation data helped me to maintain the focus on the nursing standpoint with the curiosity to understand how those experiences were organized. IE influenced my analysis as it is a critical feminist approach, and the purpose is to explicate the social ruling relations of home care nurses' work to understand the organization and objectification of the relations.

Qualitative Research Conventions – Rigour and Generalization

Generalizing finding in IE "relies on discovery and demonstration of how ruling relations exist in and across many local settings, organizing the experiences informants talked about" (Campbell & Gregor, 2008, p. 90). In IE, analysis employs what informants know and what they have been observed doing in order to identify and trace the social relations that extend beyond what they see in their experience—the trans-local and discursively organized relations (Campbell & Gregor, 2008). The goal of IE is not to generalize about the group involved in the inquiry, such as home care nurses, but rather to "find and describe social processes that have generalizing effects" (DeVault & McCoy, 2002, p. 753). IE does not aim to show that all settings are the same but rather to identify the ruling features that are operating and coordinating work in different settings (D.E. Smith, 2006b). Through my analysis process, I maintained the focus on the extraction and identification of the trans-local relations and discursive organization to support the generalization of this work.

To ensure rigour in my inquiry, I utilized transcripts of interviews to support in-depth analysis, and I documented when and how texts were used to ensure they were not viewed separately from how they are taken up in work (D. E. Smith, 2006a). I used multiple analysis

processes including mapping, indexing, and reflexive notes. These processes ensured I was maintaining a focus on the materiality of the data. I met with the THCC team and my dissertation committee to discuss my analysis processes which helped to ensure I was not slipping in my approach or making assumptions about the data. I also noted language and how it was taken up by the nurses and reflected in texts. This helped me focus on the tangible use and linkages of the work to text and coordination. As Rankin (2017) highlighted, the analytic threats and the structure of findings took time and a process of writing and thinking to expose the institutional links, using data and reflective, iterative, "relentlessness empirical" (p. 10) processes. By mapping the text-work processes of the participants I traced the tangible coordination of nurses work through texts. The tracing and showing of these processes build rigor as it ensured that I maintained a focus on the data from the perspective of the nurses and their work, keeping my focus on the empirical tracing rather than abstraction (Rankin, 2017).

Conclusion

In this inquiry, I used IE as an approach to investigate the social organization of home care nurses' work and learned about the work of nurses to explicate what ruling relations are organizing their work. I utilized interviews, observations, and texts to collect data about the work. Through an iterative process of data collection and analysis, I used mapping and accounts to identify, link, and explicate the ruling relations and social organization of home care nurses. Analysis of language and discourses present in the nurses' work and texts was central in the analysis. In the next chapter, the work of nurses will be described as a first step in identifying how nurses' work with the itinerary is influenced by the larger institutional complex.

Chapter Four: A "Jack of All Trades": The Work of Home Care Nurses

To identify the social organization of home care nurses' work, the work itself must first be understood. Through data collection and initial analysis of interviews, texts, and observations with nurses, tensions around the morning work of organizing client care, scheduling, and information sharing became visible as issues for the nurses. Nurses participating in this study articulated some of their concerns as the "circus" and the need to "ration time." In this chapter, I provide an ethnographic view of these work issues from the standpoint of home care nurses in their daily work. The accounts in this chapter highlight tensions that link to ruling relations embedded in the health authority and in government policy and regulation. I begin by introducing the settings of the inquiry and the roles that nurses have, identifying the implications of their roles on their work. Using accounts from nurses' interviews and observations, I provide an overview of the complex work of home care nurses moving from the start of the day, before clients are seen, progressing to care on home visits as well as after care, and concluding with the return to the office for documentation, establishing supports, and referrals. To close this chapter, I highlight how nurses talk during and about their work and show institutional influences on their work.

To describe and contextualize the work of home care nurses, I share specific accounts from the nurses who participated in this study and draw upon observations in their work sites. I have assigned the following pseudonyms to the nurses who explained and shared their everyday work: Anne, Bob, Bonnie, Ginger, Jen, Kim, Pat, Ray, and Ruth.

Home Care Settings

Home care nurses in this study worked in office settings, clinics, and in client homes. The nurses worked in two different communities: a mid-sized city in Western Canada and a smaller,

more rural community, both within the same health authority administrative area. Home care nursing programs are located in buildings called health units where community health programs are located. The health services offered from the spaces can vary but often include public health programs along with home care and other community-based services such as mental health and addiction services. As described previously, the nurses in this study worked in four health units: one in the small community and three in the mid-sized city. Although the buildings vary in size, all are standard, square built, constructed in the 1960–1970s, with parking and locked access for the public. Despite being public buildings, the buildings have significant signage restricting access to the general public and locked doors that require special security to enter them. The nurses explained that the restricted access was new, because of COVID-19; however, from an observer's perspective, the entrance to the "public space" is not welcoming or inviting. Staff often bustled by people waiting at the front doors, using their key fobs to enter into the building. Multiple signs and notes provide direction on how to call the front desk to ask to be let in. When onsite, I often saw families waiting to enter for public health services as I lingered by the front doors waiting to be met and let in.

The building configurations vary between the health units; however, there is a similar organization of the space. Home care nurses work in open office spaces with desks that have phones, computer monitors, and laptops. The spaces are often organized into work teams grouped by geographic area, as nursing teams are often assigned to specific neighbourhoods. Within the pods, the nursing desks are connected and separated from the other teams by a divider or hall space. There is a buzz of activity in the offices; without walls, conversations with clients and colleagues can be overheard. Laughter, disagreements, phone calls, and waiting-on-the-line music can be heard, contributing to the constant din in the space. The organization of space also

means that nurses are rarely sitting at their desks for long, as they have to pop up to collect charts, walk to fax and photocopy machines, pick-up mail, or speak with colleagues. There is a constant movement of staff around the space. Many of the divider walls have posters of processes or reminders about documentation and procedures, lists of phone numbers, and other health authority produced materials. There are sign-in sheets for staff to complete as they arrive in the morning and large white boards listing where each staff member is working posted in the large health unit in the mid-sized city. The home care nursing managers, leaders, as well as administrative support management and home support managers have designated offices with doors that close on the outside of the building space. In the centre of the building, the nurses and other home care staff work together in the open space. In addition to home care nursing, the home care offices have administrative supervisors and managers, and home care staff, including physiotherapists, occupational therapists, case managers, and clerical staff.

Each health unit has a designated home care clinic space where clients come into the health unit to receive nursing care. Clients who are able to be out and about in the community are expected to come to the clinic to receive home care nursing services. As well, clients who live in high-risk home environments may be asked to come to the clinic to receive services. The identification of high risk will be discussed further below. The clinic spaces are located in a separate area from the nurses' cubicles. There is a waiting space and the clinic rooms have a computer, an examination or treatment bed, cupboards for supplies, and a counter and sink for nurses to use.

In all the health units there is a central supply room where staff can gather supplies and borrow equipment for their client care. The supply rooms are well organized, with rows of cupboards lining the walls with labels indicating which supplies are in the spaces. In the large

health unit space, there is an island table in the centre of the room where nurses can set their bags and move about the room to collect their supplies. Nurses were provided with standard bags to carry their supplies in; these are large plastic-type shopping bags with the health authority logo on them. Nurses move about the supply room with their lists, selecting the items they need. Most nurses organize their supplies as they collect them into small paper or plastic bags per client so that it is organized in their larger supply bag. As a result of COVID-19 restrictions, there are rules about what can and cannot be returned from the client's home to the supply room, so there is a specific return area for some supplies and equipment. In the morning, while the nurses are collecting their supplies, there is often a buzz of activity and conversation as the nurses check in with each other both socially and about the clients they will be seeing. When I visited the supply room, I heard conversations about products to use, nurses asking each other for advice, sharing updates about clients they had seen, and updating each other on what supplies are in the home if a nurse had seen the client previously. One drawer was designated for Level-2 wound care supplies. If nurses were using products from this drawer, they needed to sign them out on a specific sheet, as those products cost more money and needed to be tracked. The room is kept stocked and organized by a clerk who is assigned to the supply area. The clerk assists with assembling some packages of supplies and labels them in brown paper bags for the nurses to take. The packages the nurses put together and the supplies needed varied amongst the health units.

Clients' paper charts and binders are located on various bookshelves and spaces around the health units. Some are close to the teams that are using them and others are farther away, resulting in nurses walking up and down the hallways to sign out charts and collect the paper version of documentation that they need. At the time of this inquiry, staff were being moved to

new offices or reassigned to new space. In addition, due to the COVID-19 pandemic, some staff were working remotely and gathering spaces such as meeting rooms were restricted for limited numbers of occupancy. Nurses shared that although they were permitted to work remotely during the COVID-19 restrictions, it did not work for them, as they needed to come into the health unit to collect supplies and gather the physical charts for many clients. Some nurses said they occasionally returned to their personal homes to complete their documentation as it was quieter than working at the health unit.

In summary, while the majority of nurses worked a day shift, typically from 8 a.m. until 4 p.m., some nurses in this study worked an afternoon or evening shift, providing care to their clients later in the day. A later shift often signalled that nurses were assigned to care for a client newly discharged home from the hospital. New admissions to the home care service might require a longer visit to enable orientation, assessment, and physical care or problem solving for clients who may be experiencing acute palliative care needs. The nurses organize their shifts into time to prepare to see clients, which occurs in the office, travelling to see clients, meeting and providing care to clients in their homes, and then travelling back to the office and completing post-visit work. Their days are full and they are often dashing out the door to drive to clients' homes, determining how long it will take to get there and find parking, and thinking about how to gain access to the house if it is an apartment. During the day, while out on their visits, nurses continued to organize and shift their time and client visits, planning on when they can, or if they can, take a break while they are out accounting for the travel time and what needs to be done when they return to the office. Nurses working the evening shifts are often alone or working with limited staff, so the office is quieter, but they have less access to supports and peers for checking in. The times that nurses are working affect who they will see, when they are in the homes

providing care, and who they are able to reach for follow-up and referral discussions when they return to the office. Families who are working and also caregiving may be available and present in the evenings and at times may not be home during the day shifts. When nurses are working evening shifts, physician offices, nurse practitioners, clinical nurse specialists, and other health care practitioners may not be available, except for after-hours services. As such, the time that nurses are scheduled impacts the work that they are carrying out.

Nursing Roles and Implications

Home care nurses work with a team of care providers. This team can include nurses, nurse practitioners, home care providers, including physiotherapists, occupational therapists, case managers, and home support staff. Nurses are classified by union designations and have different titles and roles within home care. The job designations delineate if a nurse is full or part time, a permanent employee or a casual employee, guaranteed work or not guaranteed but offered shifts that are available within a specific area. These roles impact the work of the nurses, and I refer to their implications throughout this chapter. Within the home care nursing team, there are district, float, and casual nurses and providing leadership to the team are team leaders, clinical leads, coordinators, and managers.

District nurses have assigned geographic areas and a caseload of clients who are identified within those boundaries. Having a caseload means that the nurses manage home supports and provide specific nursing care for their clients in their assigned areas. The clients in a nurse caseload can vary in their health care needs, from clients who have been recently discharged and require wound care changes, to those who have ongoing chronic wound care needs, chronic illness management, medication administration at home via a peripherally inserted central catheter (PICC) or an intravenous (IV) line, or have palliative care needs. District

nurses also coordinate and manage home supports for clients who have shorter term needs. Home supports are provided through the home care program by care aides, often called community health workers. The care aides can have a range of training from a short 12-week certificate to a 10-month program, and their roles and responsibilities can differ with this variety of training. The care provided by community health workers includes supports for clients such as medication administration, bathing, assistance with dressing and transferring from bed to wheelchair, and minor meal preparation. Nurses provide the care plan, delegate care to, and problem solve issues that come up for community health workers. Jen identified that as a district nurse she had a caseload of 86 clients with a variety of needs. The responsibility that comes with managing the clients in the district was stressful and had a "different element of responsibility," as she was the main point of contact for all the clients on her caseload as a district nurse (Jen).

Clients with longer term home support needs may be referred to case management. The Case Management program is a part of home care; case managers are either nurses or social workers who assess for supports, allocate home supports, and coordinate and evaluate ongoing home supports required by clients as well as other community supports such as respite services or community bathing programs. Case managers collaborate with home care nurses when their clients require nursing care and work independent of nurses if their clients are not requiring nursing services.

Those identified as float nurses are assigned clients daily for follow through with the care and case coordination but do not have an ongoing caseload of clients. The client assignment is completed by the district nurse, and the clinical services coordinator may be involved with the assignment of work as well. Casual nurses are scheduled by the clinical services coordinators to work when additional staff members are needed. Casual nurses may be needed to cover vacation

time or when a nurse calls in sick; they may also be called into work if it is a busy time and the coordinator identifies an increased need for nursing services. Casual nurses may be assigned to cover a district nurse area if the nurse is away or may be assigned specific clients to work with, similar to a float. Casual nurses are not guaranteed work and may have a schedule ahead of time or be called in last minute. Ray identified herself as a casual nurse, but she stated that she does not worry about getting enough work as there are always shifts for her. Ray went on to explain that although she is in a casual position, in some offices she is the most consistent nurse there because there has been so much turnover in nursing staff.

In the smaller office there is a team lead role, one of the nurses carries a cell phone each day to respond to urgent calls received and coordinates the schedule of client assignments for the next day. Across all sites there is a clinical lead, clinical service coordinator, and manager who may or may not be a nurse and provide leadership and managerial support to the nursing and home care staff.

In summary, the work carried out by home care nurses within these defined contexts, times and spaces is implicated in a multitude of complex outcomes. For example, district nurses have designated work space, a desk, and supplies in the health unit. The float and casual nurses do not have designated workspaces, so part of their morning work is locating a place to work from that day and collecting the supplies they will need including a computer, cell phone, internet hotspot, and office supplies. There are differences for the nurses in where they work, how they find their clients, and the follow up that they provide, which I show in the next section with specific examples of nursing work from distinct phases of home care provision.

Before Direct Care Begins

The Morning Circus

To begin the day, nurses arrive at the health unit, gain entry with their key fobs, and make their way to their work stations. It is a busy time in the morning, with many staff arriving at the same time, often meeting the halls or stairway on their way in. Nurses sign in on the daily sheet to ensure they get paid and then find their work for the day. The process of identifying where they will sit to work, which clients they will see, when and how long they will see them, and why they are seeing them is a complex process. The home care nurses must gather information, prioritize, talk with other staff, and walk about the building to find the people and information needed to pull together their day. Bob identified this part of the morning as a chaotic circus.

> It can be a bit of a circus of just like you spend the first hour actually figuring out who you are going to go see that day, because there is a lot of back and forth, back and forth, "Oh, this person is going to be an hour and a half long visit; I don't think I have time for that." "Okay, I'll take these 2 smaller visits and then I'll give you this larger visit because I have to go all the way up in X area and Y area." It's just like, oh my gosh, the logistics of it all definitely plays a role in who gets what assignment. So it's not as easy as, "Oh, I'll just go up and see these five people." There's a few extra pieces to consider. (Bob)

In summary, the work needed for home care nurses to organize their day is often unseen or uncounted in workload calculations for home care. There are no written procedures or policies for accomplishing this morning organization work; however, in observing nurses across sites, I found it was completed in remarkably similar ways. The organizing and prioritizing work completed by every nurse each day is required in order for the nurses to provide their nursing care, and none of it is recorded on their daily itinerary forms.

Finding Work – Who Will I Provide Care to Today?

One of the nurses' first steps in the morning circus is arriving, signing in, and finding their workspace. Once situated in their respective office spaces, nurses determine the clients they will be seeing and create their visit schedule for the day. As identified above, which clients each nurse sees is also influenced by the employment role the nurse has, whether they are a district nurse, float, or casual nurse. In the larger offices, once the nurses make their way into the building, sign in to verify they are working that day, they walk past a large white board that lists all of the district areas the staff assigned to each area and identified the team they are working with that day. District nurses will check the board to see who is assigned to work on their teams, if there is a casual or float nurse, and, if they have other team members they need to connect with, they can see who is working. The casual and float nurses check the board to see where they have been assigned to work (i.e., which district area they will be working in that day). The nursing coordinators write the assignments up on the board each afternoon based on their staffing reports, vacation planning documents, and workload in the areas (Jason). The whiteboard often becomes a gathering place in the morning as nurses look to see who else is working that day and identify which managers are in the office.

A combination of electronic documentation systems and paper records are accessed by the nurses to identify the list of clients who need to be seen each day and the type of visit they are requiring, home visit or phone call. In the larger offices, nurses use Microsoft Excel spreadsheets, Microsoft Outlook calendars, binders, and paper notes to help identify their client lists. In the smaller office, a list of clients is organized by the nursing team lead each day. The lead creates a spreadsheet that is posted for nurses to access in the morning. The nurses access

these lists and identify who they will see, who they will pass on to someone else, and who they might be able to be seen another day. Jen shared,

> For example I can't bump daily IV antibiotics, but I can bump a skin check to the bum, so you just kind of look at what you know what is the most important, maybe all of your things are important, maybe not, and so you move those things that can be moved.

The number of clients that each nurse is caring for is considered in creating the list of clients who will be seen in a day. There is, however, no fixed minimum or maximum number of clients that a nurse must see documented anywhere. The district nurse reviews the nurses' client lists and determines which clients they will see and when:

> Nurses who manage their patient load are really encouraged to take a look at their week and disperse the workload as evenly as they can.… We kind of triage that way.… There are certain days where you … look [and say,] "Okay, I know I am not going to get a lunch break," or, you know, "I'll work a bit later." Sometimes with manager approval we can move some visits onto evenings, which we did today, actually, so we do definitely defer, and yeah then you just kind of look at what float nurses you have available and then sometimes also … the good nurse teams sometimes will say even if you are managing your own geography, if the other geographic nurse over there is way more full than you, you could take a couple from her. So you kind of do shift within the greater picture as well … to make sure that the workload is distributed evenly among the nurses. (Jen)

In addition to finding the clients on either the computerized Microsoft Outlook calendar or the Microsoft Excel sheet, the nurses use a district nurse binder to confirm and organize their client lists for the day. This large binder is organized by date and month, and each section

contains a set of sheet protectors with client label sheets filed into the date they are to be seen next. The nurses review the client list on the online shared calendar and compare the names with the client sheets from the binder to ensure they have scheduled everyone who is supposed to be seen and no one is missed.

For casual and float nurses the process of determining their daily work is different. If casual nurses are assigned to cover for a district nurse, they will see the clients that the district nurse was assigned to for that day.

> I come in and, for example, today, I was sitting in somebody's district.… She is off, so I'm taking her workload. I am looking at her calendar, but maybe she would be there, so I would just be extra. So, I would show up in the morning and whether I am sitting in the district or I am taking some workload I will get a patient load. (Jen)

For nurses who are not assigned to a district, part of their morning work is negotiating a list of clients to see that day. Jen, currently working as a float nurse, shared, "So they are kind of like work relief. So the regular district nurses offload their busy days to the float nurses."

District nurses often express gratitude for being able to pass clients along to a float or casual nurse; however, there is also hesitation and decision making around which clients they will give to the other nurses.

> Usually we do have, like, one float—one or two. It's wonderful when we have that.… They usually help whoever is the busiest, has the busiest calendar for the day. They'll go and help them out, or help everyone out a little bit. (Kim)

Bob stated, as a district nurse, he thinks about who to hand off to the float:

> If I needed to delegate, sometimes we have a float nurse that I would … hand over to them, and, as a district nurse, you delegate to LPNs [licensed practical nurses] and

> registered nurses if we ever have registered nurses floating, that's a bit of a more rare thing. We usually have LPNs, and that can be kind of challenging because their scope of practice is different, and sometimes I'll have six visits … or seven visits, but I can't actually delegate any of them away, so I personally have to do all those visits and then that's just a busy day.

In summary, identifying who will see the clients and for what care is a complex process. Nurses must think about who saw the client last and try to maintain consistency in who is completing the visits, timing, location of the visits, scope of practice, and if care can be delegated to others, and other considerations as they plan their day. Nurses have regulated scopes of practice set by the British Columbia College of Nurses and Midwives (2020), and the process of delegating care is linked to scopes of practice and regulated by the college. As a result, the work of determining clients and visits appears chaotic as nurses gather supplies and information from multiple site and electronic documentation systems before going about their day, caring for clients.

Scheduling the Work – Who is the Priority and When Will I See Them?

With a list of clients in hand the nurses plan their schedule for the visits and calls that day. The nurses face multiple considerations and must draw on multiple sources of information to make decisions and plan client visits. When organizing the schedule for their work, the nurses determine who needs to be seen first based on their care needs, what time clients will be seen, and how long to schedule their visits. They consider geography, the expected length of time for the visit, client preference for visit times, and home support schedules; for example, if a client is receiving a bath with a home support worker at a specific time, nurses will set the visit at a different time. If there is a new admission, nurses receive information from the admission

paperwork that includes a priority code that states when a client should have contact (i.e., within 1 day, within 2 days, or longer). This priority category information informs their decision about when a new client needs to be seen.

> [If] it's a new admission, … it would have a certain priority that we'd need to visit them by. So … we got it yesterday and it's a pink folder that comes and it's a 1B admission.… There's a different prioritization by different letters, 1A. (Ray)

Jason explained that Level 1A indicates the client needs to be seen within 6 hours, Level 1B is within 24 hours, Level 2 is within 48 hours, and Level 3 priority is within 1 week of the referral being received. Scheduling the time for client visits is impacted by external influences. While nurses try to be flexible and responsive to clients' needs, there are also clear priorities for times for certain tasks, particularly IV medications, and if two nurses are needed for a visit, those are scheduled first. Ray identified that IV medications are a priority for scheduling, and that the timing of these is set by the hospital IV team, an external group that works with clients and directs the timing for home care visits: "If giving IV medications, you want to keep things consistent.… The documentation that comes from the IV team at the hospital also has said what time—they've determined the timing, so we're just following the timing."

As a part of their scheduling work, nurses determine how long to see clients for, setting a block of time that they will be with the client for their care. The list of client names on the shared online calendar or spreadsheet does not specify how long to see them for, so the nurses determine this each day as they set their schedules. The decision is informed by the type of care the client is receiving and other details about the client's needs that the nurse collates in their research on the client. Ray stated, "It's a bit grey.… It's [a] very clinician individual thing. In our

calendar, it's not very specific for how much time things take. We usually only put them for like half an hour or an hour" (Ray).

Scheduling client visits requires the nurses to identify the reason for the visit and then the length of time needed. In the larger offices there are unwritten rules about scheduling 15-minute blocks for phone visits, 30-minute blocks for home visits, and longer blocks ranging up to 1 hour for new admissions or palliative care visits. In the smaller office, the nurses continued to use the count system to determine the length of visits; the count system identifies how many minutes each client will be scheduled for based on a set of guidelines for type of visit per point or block of time. One of the nurses in the larger centre shared,

> They [home care managers] took out what was called a points or a count system, so nurses were expected to take a certain count, and a count of one was half an hour, so you kind of worked your workload out that way. But now it has kind of changed.… [We] don't do that anymore, and I have heard some senior nurses talking about there is a 100% palliative visits or complex visits that are an hour, an hour and a half, three hour visits, and that is something very difficult to represent in our workload because the culture in our office,… people will never schedule a visit for longer than an hour.… We have had managers … shorten them [the visit times] down to an hour. (Jen)

It is interesting to note that one office continues to use the count system for scheduling and the other offices are no longer using the counts. However, the standard blocks of time that nurses use to schedule client times follow the same count system format quite closely. Jen also identified that their scheduling practices are overseen by their clinical leaders and that the leaders will override the nurses' decisions about scheduling and decrease visit times if they see larger blocks of time being set for client visits, as this occurred once on her schedule. There are also

unwritten rules about planning visit times, when to leave the office and return, and nurses were not able to say where they received this direction from, other than it was how they saw others setting up their day.

> We tend to see most people between 10 o'clock and 1 p.m., [that] is when most visits happen, [and] people tend to be home at that time, they tend to … learn the flow, and … it gets interesting when we go to assisted living facilities as well and people have lunches at certain times, and that gets really challenging to like avoid people's lunches because their all at different times, and people have to eat, so you can't just be like, "No, you can't eat lunch." Of course you're going to eat lunch, so we're going to [be] flexible [about] this, but it does, it makes all of our other visits a bit more of a challenge.

One district nurse discussed how having relationships with clients can help when they are juggling multiple priorities:

> In a perfect world they would say wound care is half an hour and then palliative care is an hour. But, … it totally depends on your day. Like, if you have too many people to see, sometimes I even prompt my client, like, I phone them in the morning, I just say, … obviously without being insensitive, if I know the visit is pretty quick, I would premise it with, "I am really busy today, so I apologize that I can't spend you know a half an hour like I normally do. Is there anything pressing? Because, if not, I'm going to be pretty quick." You know, but the nice thing about district nursing is you get to develop a relationship with them, so sometimes they'll just be on the phone and say, "You know, I don't think I need a visit today. If you guys are super swamped, I can manage on my own." You're like, "Great. I know you. I can trust that this will be okay, so I don't need to see you today then. Thank you." (Bob).

There is also an opportunity in this scheduling review and decision making to evaluate if a client's care needs to be rescheduled in case there has been a new priority admission or an urgent visit request takes precedence. Kim described the challenge of managing her schedule when emergent needs arise:

> Personally, I've had really bad days where I'd had two crashing palliatives at the same time.… So if I can only do one palliative, I like to switch it up and do something else just because I feel they take the most precedence in your day, and when you have two that are crashing it's terrible.

Participants also identified that their coordinator may assign new admissions to evening nurses or float nurses,

> because we have that time to be in the home for the hour, hour and a half it may take to get all the forms filled, and deal with issues with the clients and then come back to the office and do the barrage of paperwork that's required. (Pat)

This scheduling practice for time management has an impact on the continuity nurses can provide for their clients who may not see the same nurse again if their care is later assigned to the district nurses.

While working on the schedule and determining the order and timing for their visits, nurses contact the clients to let them know when they will be visiting. Jen described the discussion of the timing of her visits in this way:

> So generally speaking, really good nurses will give them an hour window because that keeps everybody less stressed. Like, if you are running behind, you don't need to worry, and then some cheeky nurses will be a bit more like, "You know, … they should be around for us," so they will just say, "I am coming in the morning," but then sometimes I

> give them half an hour windows so … whatever your style is about when you are going to be by. (Jen)

The terms “cheeky nurses” and “really good nurses” highlight areas where Jen reveals expectations for nurses’ practice, what is expected and acceptable and what is not. Several nurses noted in the process of setting their daily schedule that there is an expectation that clients will be available for home visits at any point during the day: “Most of our clients, we tell them, “Because you’re homebound, we can see you anytime between like 9:00 a.m. and technically 8:00 p.m.” (Ray).

In summary, there are unwritten expectations that nurses follow to set times for their visits and how they plan their time and there are judgments around how this is good practice and sets expectations of clients. In the next section, I discuss how nurses come to know their clients.

Coming to Know the Clients – What Care Will I Be Providing?

As the nurses work on organizing their daily schedules, their planning includes both learning about their client and the care they will be providing. To complete this work, nurses must access multiple electronic documentation systems, physical binders or charts, informal sticky notes on client files, as well as verbal reports shared by talking with other clinicians about previous care.

For district nurses who know their clients, the process of reviewing their client needs may be a quick check if they had seen them the previous day. The nurses look at recent documentation to learn what is new with the client and to identify any changes in the plans for care. For the float and casual nurses, if they are not familiar with the clients, they begin a process of discovery, looking to find information on the client to help them plan their care. Unlike other care settings where a nurse may receive a verbal report sharing information for continuity, in this

setting the nurses rely on the electronic documentation systems and notes that may be left on the client sticker charts in the district binder. Ginger shared,

> If I am not familiar with the clients then I would … go into their PowerChart[4] and I start reading all the, all of the several million places there is to kind of get updates on them to figure out why I am going there, where, how long this visit may or may not take, is there any special considerations for the visit I am about to do, their geographical location, reading up on their SSAP [Staff Safety Awareness Planning].

With new client referrals, nurses take time to learn about the client and their situation and needs prior to their visit. Bob explained that he looks on PowerChart to identify the reason for the visit, collects collateral information, does a bit of research, identifies what supplies will be needed for care, reads discharge notes and history as well as the medication list, and then pulls together the paperwork that he will need to complete. When nurses access PowerChart, they search each client by name or medical record number (MRN) and open their electronic file. There are several tabs, windows, forms, and documents that can be accessed on each client's record. The first page of the PowerChart file has communication notes that nurses can review and add to. Then layers of pages and tabs provide access to pages for documentation and notes from other providers. This process of coming to know the client takes a considerable amount of time, which Jen described as "detective work." Similarly, Kim stated,

---

[4] PowerChart is one of the electronic documentation systems that is used in home care. PowerChart is where nurses document their care plans, care provided, and can record notes to share with other health care providers. It is accessible to staff within home care and externally to Island Health staff in acute care.

> I will get the referral and read it, some of them have a lot of information where you totally feel like you have a sense of what's going on and some do not and you have to do your research and kind of dig, but usually reading it, seeing who sent it. It's good to have a good sense of if it's coming from the hospital, if it's coming from a family member; that really tells you a lot usually as well. And then I usually look them up on PowerChart and see their history: if they've had any recent hospitalizations, if they have any like good progress notes or documentation from the doctors, just to get a sense of what's going on with that person, and you can also kind of see who's involved in the care as well with that, if they have any specialist or what have you that can document on there. And then a lot of the times other interdisciplinary teams need or are already involved, so we can go on another program called PARIS [Primary Access Regional Information System] and kind of see there as well who is involved.

Many nurses also use sticky notes or notebooks to identify what to do on the visit, what to take with them on the visit, and to track additional contact information or details.

> I have my own personal method, which is yellow sticky notes that I write, especially if it's somebody I don't know, it's my first time meeting them. I pull them up, I see what needs to be done, I write it out on the sticky note, and then I take that sticky note and I put it on the front page of their travel folder. (Anne)

Nurses developed their own ways to record the information they need to provide care and keep track of the pertinent information for their work. These workarounds included writing up sticky notes, keeping notes on a lined sheet of paper, and writing information in a notebook.

In addition to accessing information on the electronic systems, nurses also access physical charts and smaller travel charts contained in the physical chart for their clients. The

travel charts are required to take to the client's home if the nurses are providing medications, as all medications are recorded on paper and not the electronic system.

> We have their BPMH in there, [which is] their Best Possible Medication History. [It] has the copy of the SSAP [Staff Safety and Awareness Planning] in there for any safety concerns, their allergies, and then usually we try to print off if there is a wound treatment plan … and if we need to be documenting any medications administered, those still have to go on a piece of paper with a wet signature in the paper chart. (Ginger)

At some point in this work to organize their day, the nurses need to phone in to the morning huddle call. Huddles were held in person prior to the COVID-19 pandemic; however, since the restrictions, they shifted to and have remained a telephone meeting. The huddles are a virtual meeting held over the phone. They provide an opportunity for the nurses to let others on the team know who they are seeing that day and for clerical staff to share information about new admissions and discharges from the hospital. During the huddles, nurses continue their morning preparation for their client visits.

Onsite with nurses, I observed them call in to the toll free number for huddles. They put their headsets on, or left the phone on speaker, and as the leaders introduced the day and called on each team to list who they were seeing, the nurses were listening and also accessing their computers. As they half listened to the call, nurses continued to plan their day and work on their preparation for visits. I observed nurses looking up addresses on Google maps, checking the latest lab results and notes, and making a list of supplies.

> We do a phone-based huddle, so … our leadership speaks, we go through all of our different programs, and they each speak to anything that's come up in their day that may be relevant, and then we go around to each geographical team. Everybody reads their

> client list, so it's a good way for us to kind of all be in a loop of what's going on that way, and it can kind of serve as a trigger for people to have those conversations. (Ginger)

Jen shared that before COVID-19 the huddles were a nice way to connect in the morning and management would provide updates and sometimes there were quick in-services or updates about new equipment or procedures. She lamented that now they are online there is not the same engagement, and it seems like people just read off a list of their clients and nurses are not fully listening. Jen said she even uses the time to continue her work so that she can head out on her visits. In one instance, while observing with Jen, she identified a client that she was going to see on the call and a social work colleague on the huddle call asked to speak to her before she went on the visit. After the huddle call, the social work colleague walked over to Jen's work area and they had a conversation about the client and the plan of care. Jen said this was really helpful as she had not seen the client before and it was good to know the history and plan.

Before leaving for their client visits, the nurses collect their supplies and ensure they have what they need for the client care and their technology for charting and checking in. A part of collecting supplies is consulting their lists of what is needed based on their detective work in determining what care they will be providing to clients. The nurses must also determine what supplies may be already in the home, paid for by the health authority, or needed in the home and paid for by the client. Rules are in place that determine which supplies will be paid for and which supplies the clients are expected to purchase and have in their homes ready for the nurses to use. Ray shared, "People with IV stuff … a lot of their medications are provided to from the hospital IV team [and] all of their IV materials."

For clients receiving wound care there is a 2-week cut-off period for wound care supplies provided by the health authority after which clients must buy and provide their own wound care

supplies. Nurses' work includes knowing which supplies to bring, coordinating this with clients and communicating to them about the expectation to purchase supplies. Kim identified that the 2-week period for supplies is often "overlooked" by nurses. Funding can be accessed for clients who are not able to pay for their wound care supplies after 2 weeks and Kim referred to this as a supply request form that the nurses can complete and send to the physician so that the client receives funding for their supplies. However, funding is limited, and only certain clients can access it. Kim stated, with the "demographic we work with," it is often not realistic to access these funds. Kim identified a client information handout they give to clients to help them with purchasing their supplies; it has the names of the pharmacies where clients can purchase wound care supplies, a list of what supplies they would need, and the costs. "They can … purchase it themselves but people are resistant to it a lot of the time" (Kim). The burden of explaining costs and identifying lower price items for client care falls to the nurse, and they must carry out these difficult conversations about payment for supplies in the home, while providing care to clients. Nurses, as part of their client care, are expected to have these transactional discussions highlighting the health authority's focus on user pay systems.

Once the nurses have created their schedules and have their supplies, they need to record their schedule for the day on an itinerary form, which nurses identified as a tool used to document their visit schedules both virtual and home visits and for tracking safety.

> I'll take my itinerary sheet that I showed you and I take the stickers, and … I put who I am going to see and who I am going to phone—and I'll put them on my sheet and then I normally write if I need to bring supplies. I kind of make a little note at the bottom of the supplies that I need to bring, and I'll write just for, I usually know why I am seeing the person, but I could write like, "dressing, antibiotics," whatever. And that information,

> like the supplies to bring and what I'm going for, is for me … to look at and then admin.… So and then I photocopy it, once I am done filling it out, and I take the photocopied version and leave the hardcopy for admin. (Kim)

The preparation and organizing work are completed within the first hour to hour and a half of the nurses' morning. The intake of information, prioritizing, decision making, and hunting for information is all preparation to determine the schedule and the flow of work for their day. Once the nurses determine their schedules, they document their plan on the itinerary form and leave a copy with their administrative staff, they head out of the office for their visits. The sequence of how the nurses complete these morning tasks of organizing their day and collecting supplies can be different, but the work is the same; unwritten norms appear to be followed as nurses share the sense of this work needing to be done and get out of the office into the visits as soon as they can so they can complete the visits and return to the office to complete their follow-up work. This account from Bob is a longer narrative but his reflection on the morning highlights the work involved in preparing for the day. In this first statement, Bob identified the work he has as a district nurse to manage the communication and care coordination of clients:

> Just sorting people out can be quite a struggle to say the least. But, essentially, I do get to work half an hour early and I look through, because we get emails a lot, of course, with COVID and stuff, so I do try to like keep up to date with my emails, and we get emails from Home Supports to say, "Care plans need to be changed from the Home Supports side." So we have our feet in a lot of different buckets and a lot of the responsibility does fall on to the district nurse, and so I could spend a whole day not seeing anybody, but physically working and physically using my nursing skills and assessments and stuff but

not actually seeing clients, so there’s a lot of extra work that’s to be done by a district nurse.

In his description of the morning circus, Bob detailed the steps he systematically moves through; however, the process of completing these is back and forth and involves moving about to different areas and to different people in order to pull together his plan for the day.

> What does the morning look like? So, we all have …our green nursing district binders, and we flip to the day that it is.… I would see all the handover notes there, and I would take them out, and I would match them up with a calendar on the computer, and then I would start my day.… I would get their actual charts, because that’s got, you know, vital information about the visit.… If you need to make a phone call to their doctor, it has all the staff safety awareness stuff, so if you know they’re a violent person or if they have pets and stuff, just some of that because you really don’t know what you are walking into. You know, you kind of forget that people don’t live like you and me; people live in very dilapidated situations and that can be a safety concern for some of the nurses—well, all of the nurses, but not everyone’s going to see them. So, yeah, and then I would gather my equipment. If I needed to delegate, sometimes we have a float nurse that I would give my handover to them.… We do a morning huddle, so we spend, you know, 15 minutes with all of the group saying who they’re going to go see, because sometimes it overlaps with like a social worker, or a physio, or a case manager, and then you can have a bit of a brief with them, and then that helps for the visit, right? It gives you a bit more recent information. (Bob)

Jen also identified the morning work as challenging. She stated she was glad to see me observing the morning organization because it is the most inefficient part of the day. She shared

this comment as we walked back and forth from their work area on the computer where she was accessing client information on the electronic system to the chart room where she needed to sign out the travel chart and review notes in the physical chart before returning to her computer station to complete the review of the client information. Rationing time and care for clients is a concern she identified in her account:

> I am always playing around with how I could be just a bit more just calm throughout my day because I definitely feel this pressure of myself racing the clock, and I don't like that.… There has definitely been quite a few days where I just think to myself, I could have done this better if I wasn't rationing. Like this is a really simple thing that I missed, that if I …just felt like … I had the time to read this full e-mail or do this research, I would have been a lot more efficient, or, you know, all of the tasks they wanted me to complete, I would have noticed.… I am trying to stay calm in the morning, but often the morning before I leave the office is … kind of racing the clock, because if you get out of the office early, … you normally feel like you have a bit more space in the day. (Jen)

In summary, nurses' access multiple sources of information to identify the clients they will be seeing. As nurses determine their clients for the day, they are learning about the client and their care needs, which helps them to establish their schedule and priority in the day. Nurses juggle their time to ensure they can see the clients and provide the care needed.

During Care – Home Visits

Visiting clients to provide care involves travel to their homes, gaining access to the building or house, having permission to enter, and delivering care. The care provided on visits has some features that the nurses identify as unique as they are entering into the client's personal

space, expected to deliver care, while also providing mandated agreement forms and financial assessments, and are alone often in the environment with clients and their family.

> Just going out and seeing what a home visit is like, you know you are going for wound care but it's not just wound care, right? So it's the whole thing and the big picture, and just getting used to that, it's … community nursing is out of a lot of people's comfort zones, right? You are going into someone's house, so you're on their turf, and it's a little different. (Anne)

Providing care in the home is different than providing care in clinical settings. Ruth shares the broader picture of what she sees and how she engages with the clients:

> Because you can tell if they are diabetic, you can tell, are they drinking small little cans of diet pop, which he was, or do they have like a case of full on sugar soda at that front door? You can tell if they have a hard time letting go of things, and maybe their mobility is changed, and they have a lot of clutter in their home, but it's simply because they can't get out to remove it. Sometimes it's because they can't deal with parting with it. So it's just those other pieces that you would never see in the hospital, or like how an actual person functions and where they keep their medicine—if it's organized, if it's just there's medicine in every single room of the house, which sometimes you find, there's medicine in the bedroom, the bathroom, the kitchen, the living room, and I'm like, "How do you manage this?" (Ruth)

Pat shared there are important considerations in determining if clients are seen in the clinic setting for home care or in their own home:

> Colostomy-ileostomy teaching, although what we find with that is a lot of times it's better to teach clients in their own home, because then they're in the environment they're

going to be in to learn how to do this. So the clinic setting is not always the best because we aren't really set up, you know? Usually, a lot of times these people are going to be standing in their bathroom, at their bathroom counter, and have all their supplies ready, and they're going to be using their own mirror to help see the stoma and kind of you know clean it, and put the new appliance on, and so it's almost better in those cases, even though they may be well enough to come to our clinic, it doesn't provide that setting that they kind of need to set their comfort level and just … do it in a way that they're going to always do it.

Gaining access and permission to provide care is work that is unique in the home care setting. The clients can determine if they let you into their home and space to carry out your nursing work.

> Like gaining that permission … for me, I can just see the like tension in their eyes defuse when they feel that they're in control of their health care plan, really their health. Yeah, so when you come to them …as, "I'm helping you with your health goals." … You come to them as like you're helping them rather than telling them. (Bob)

Ray identified that gaining consent to provide care is important and different in home care compared to other practice settings.

> If they welcome me in, … it's that constant journey of remembering that they're providing consent for us to come into their homes as well. In hospital life, I think people sometimes assume consent a little bit too much, where you're kind of knocking on someone's door, [but] you don't even knock, you just go in.… People will often just go into clients rooms, whereas I think the consent piece in homecare is very big, where like if someone doesn't want you to come, they won't pick up the phone, or they just like

won't buzz you up to their suite, or they just won't open the door. It's a pretty simple consent.

Setting up and finding space to deliver care is part of the work nurses have when entering into a client's home. Unlike more standardized care settings where the nurse may have control over space, in the client's home, nurses enter and need to negotiate the use of that space, determine where to set up supplies and provide care that is safe for the client and themselves.

> He was seated on his bed and so he was kind of like moved over a little bit closer, so he's got his legs off the bed and there was like some tables that had a lot of stuff on them, at the sides, and I was like, "Hey, do you mind if I just use this little section, right?" He said, "No problem." He was really … welcoming and agreeable also cause he's been having this daily IV done for a while, that's one thing as well. A lot of clients that we see, not all of them, but a lot of people we see, they're not new to the medical system, so they're quite used to having people in their space and people, a lot of our homecare clients as well, we've been seeing them for years, so they're used to the routine, if anything they tell us what's happening. I really love working with people who can tell me what they like because it just keeps things easy. (Ray)

Another aspect of being out in the community and in homes for visits is that the carefully prepared schedules for the day may need to be changed.

> Because sometimes they can be a bit complicating, and if you don't [know] the client very well, it's like their disclosing a lot of information to you while you're also trying to do wound care within like a half an hour, so sometimes you're kind of stretched for time. (Bob)

This results in nurses needing to adapt their schedules while they are out on their visits.

> Half an hour visit can turn into an hour visit really long, or really quick. And then everything bounces from that. I was going to go see someone from you know 12:00 and now it's 1:30. I can't see them 'til [2:00], but then I have two more people after that, so then I am not getting back to the office until 4:30, so now I'm working overtime. It's like you really have to be there for the person but also be aware of your time and not dilly-dally, but not rush. (Bob)

During home visits, nurses are required to inform clients about organizational policies and expectations in addition to providing the nursing care they are there to complete. Bob identified that on the first home visits they are required to have clients sign a Client Service Agreement Form, review expectations of the client, nurse, and service provision, complete a safety assessment, complete financial assessments if clients are going to receive palliative care, discuss home supports or ongoing wound care, and are required to get client signatures for renting equipment. All of this work occurs on visits when nurses are also establishing rapport and providing care for the client and their family. Nurses are expected to carry out the role of gatekeepers for service while informing clients about the expectations the system has of them and their need to participate appropriately in the care.

Moving from home to home for the visits and being in the home environment poses some unique challenges to nurses' work.

> You're bouncing between all these different people and their different care needs, and like, I think there's a lot of empathetic burnout in the community because we're just kind of being yo-yo'd around with like each client. It would be like a float nurse in the hospital running around the floor each hour, kind of thing, like going from renal to cancer to like end of life every single hour, it's like you get exhausted, but I think if you're within the

> same realm of clients, you find like a rhythm, and it's not as like … I just know for myself like there's some days I'm just, yeah. You're just tossed around too much. (Bob)

Kim shared that home care nursing work is autonomous, and she was surprised at the lack of an educator in home care given that nurses are "alone most of the time" and they "have so many, so many different skills." She also noted that this autonomy is helpful, as they have the decision-making ability to schedule clients for their care based on their nursing judgment. Bob identified challenges with being on his own out on home visits:

> One of the hardest parts of this job is you go there and you don't have buttons at your side. You don't have staff to help out.… You are on your own, and you are so autonomous in your practice, and that's great but it's also… really scary, and like not having a computer, not having the ability to just like step outside, look something up, and then go back inside… You can feel really, it can just be really terrifying … like with some of the really vulnerable patients and not being able to just quickly work with them. (Bob)

There is also an effect on nurses due to being in people's homes. In addition to being alone and isolated as the nurses provide nursing care, there is a different connection to the clients and their lives that occurs for nurses when they are in people's homes. Bob described the impact that this connection has had for him:

> Going to people's homes and seeing their family photos on their walls, seeing how they decorate their homes, seeing the people they love and who support them, and just being privy to their life at such a vulnerable stage. It's very rewarding, but it's also very exhausting, and it's so hard not to take some of that stuff home with you. Because you see some people in like a really, really challenging situations, and … you're so immersed

> in their life.… It is hard to kind of jump back out of it, so that's … the struggle that I'm kind of working through as a community nurse.

In summary, there is little conversation about the emotional work that occurs for nurses as they navigate in and out of people's homes, lives, and care. This work includes the relational connections that Bob identified and includes the challenging work for nurses providing palliative care with clients and their families. These aspects of nursing work are not addressed in the data collection systems and electronic health records where nurses record the care they provide.

After The Visit

When nurses return to the office, they engage in a different kind of client work, the work of organization and follow-up care that needs to occur for the client. This is not direct client contact but essential in ensuring clients receive home supports, have continuity with their care plans; it is when referrals and communications are completed. This work of organizing client care upon return to the office is not captured on the daily itinerary form. The work includes documentation, referrals, and follow-up, starting and monitoring home supports, scheduling the next visit, moving the paperwork and communication along to the next team member, and team communication and support.

Recording the Care Provided and Entering Data

There is some variability on where and when the nurses complete their documentation for visits. Some nurses identified that they do their charting in their cars after they visit clients, while some return to their homes and complete the work there so that they have a quiet space and are not disturbed, and others return to the health unit to complete their documentation. Several participants noted that with the implementation of the electronic documentation system it was an expectation that they would chart in the client's home with the laptops: "We've been pushed to

do more point of care documentation.… So pre-COVID they wanted us taking laptops into every home and documenting in the home—right there" (Ginger). However, nurses reported several challenges with this expectation, identifying a lack of space in clients' homes, unreliable internet connections, and using the laptop can cause an interruption in the flow of the visit. Ginger shared,

> This isn't a practice anyone has adopted or anyone is really comfortable doing. It's uncomfortable sitting in people's homes setting up a computer and, you know, trying to work out technical difficulties, and then just sitting there and charting, and it's very in personable as well, especially during those palliative visits. You know, you are trying to connect with these people and be attentive while trying to fiddle with the screen at the same time, and then the kind of alternative to that was to chart in your car directly following the visit, it's not ergonomic, laptop in your driver's seat… Trying to position yourself in a way to properly type on a laptop in your car after you spend the 5 minutes hooking up your hotspot, connecting, pulling everything up, logging in to your hotspot. It's not comfortable.

Completing the work of documentation and referrals on the computer in the home or in the car is challenging. In clients' homes, nurses encounter varying spaces with different degrees of appropriateness. As some nurses shared, opening a laptop and waiting 10 to 15 minutes while the internet connects is awkward. Simply finding space to set up supplies for care is a challenge in some homes, and then to perch a computer on a bed or crowded dresser in a room will not work. Once an internet connection is established nurses must then open the electronic documentation systems and navigate between multiple tabs and sections to complete their notes.

The work of documenting client care includes multiple components. Some nursing care is documented on paper; as noted earlier, if medications are given, nurses record this along with a "wet signature" on the travel chart, a paper chart that they then return to the office and sign back into the client's full paper chart located in the health unit. The majority of nursing care is documented on PowerChart. Nurses update several screens on PowerChart to reflect the care they provided, update care plans, and leave notes for what is next needed for the client. If referrals or home supports are required, additional steps and documentation on different electronic documentation systems are needed. There are four different electronic systems that I observed nurses using to document or access client information on. In the following account, Bob outlined his process and the multiple steps in documenting one client's care:

> You go through and put all your notes back into PowerChart, and then we have this option … on the home page of PowerChart. On their file, … there's like an Actions and Awareness setting, so it's just like instead of leaving like a sticky note, for example, on their chart, you would just type it in there. And then on the side you could put, like, for me … I learned in school about the Kardex, … little pieces of paper that's got their diagnosis, doctor, medical procedures, like quick stuff, so I usually do that on the side with their past medication history. If there's any like sensitive topics or, you know, if they're open talking about their diagnosis or if they're not.… Just trying to get that organized so that the next nurse has a bit to work off.… So I do a like a big progress note, and I do like ticky charting, so there's like ticky documentation, and I go through that, and a lot of home care is like what we should be asking each time we go: … if the person has had a fall, and if they have a history of falls.… We're supposed to be very attuned to that, and so for my practice it is something that I ask them, you know, at least once a

> visit.… So I go through the ticky charting and then I write a progress note about it, and the calendar part, I … go to the calendar online that we use and share,… and put their name in and what the visit is about, and then on that calendar we have the ability to set recurrences. And then you would take that handover, you would bring it over to the districts that they belong to, you'd bring it to their desk, basically, and put it in on the date that they'll be seen next.

An influence on nurses' work during the time of this study was the implementation of an electronic documentation system just prior to the start of this research. The nurses identified documentation as being a "hybrid state of computer and paper" (Ray).

> So like half of it's paper, half of it's online, and you kind of just learn what to look for what where. So usually the PICC information for the safety checks, it used to always be on paper, and I actually found this past week … now done online as well.… So a lot of it is kind of switching over to online, but I guess a rule of thumb is any medication that we give, we have to write on paper still—it is not to be done online, but everything else, we chart online. (Kim)

The hybrid documentation system doubles the work and increases the time and complexity for nurses to enter their notes about client care. As identified in the morning preparation work, there is a sense that nurses need to be detectives to find all of the pieces of information and ensure they enter and file all of the information in the multiple places where it is kept both electronically and in physical hard copies. While nurses navigate where to document care information and communication notes, there is also a concern about the accuracy of information and creating other tools to compensate for the new system.

> Since we moved to PowerChart the supply lists are never up to date.… If I choose to rely on them, I will invariably not have the right things, so I have to do a lot more digging and over preparedness as far as what I need to bring with me now. People also still put stickies on the label sheet of supplies, so people, I think, they are really overcompensating to make sure that things don't get missed in that regard. (Jen)

In one example, Ruth shared a story of a sticky note left on a client file indicating they were in hospital when actually the client had been discharged a week prior but the sticky note had never been removed from the paper chart. She stated, "I thought it was kind of funny, just a sticky note in the wrong can really bugger you up" (Ruth). The mixed documentation systems have created challenges for the nurses and the work they need to do resulting in double checks and extra work. The information nurses are recording is also used as data for the health authority and Ministry of Health, which are able to access some systems and extract data for reporting purposes. Nurses, as they record their care and enter their notes, are in turn creating data sets that can be mined for information by the health authority and government ministries.

Establishing Home Supports

If clients need home support services, nurses' complete the paperwork for referrals to outline the required services. Nurses also update care plans and changes to home support services for their clients. This work process has multiple steps that can include accessing electronic systems including, PowerChart, Procura, Primary Access Regional Information System (PARIS) and email, as well as online templates to send information and request services. Nurses identify that this work is time consuming and important as they "carry the delegation" (Ray) for tasks that they are asking the unregulated home support workers to carry out. Ray noted, "We would then be the person to carry the medication management home support. …

We've delegated this task to the homecare nurse, so it's technically under our … license." The following lengthy account provides a step-by-step reflection of what is required by the nurses after an initial intake of a client to establish home supports. In this first part of Ray's account, she identified the documentation she completes for a new client, the forms required by the health authority to "set-up" the new client.

> When I get back to the office, I'm going to document all those things in PowerChart, like I said, and which is the violence, the risk of violence, the infection disease thing, the SAF, Safety Awareness [Fundamentals], the medications are all going in PowerChart, I'll hand in the CSA, the Client Service Agreement, over to our admin team, and they document that somewhere. And then I'll make a note in PowerChart about my admission, what happened, who I called,… and then I'll make sure that … [the daughter's] number is on our ASA [Action and Situational Awareness] so that whoever is following up in the future can make sure they can connect. (Ray)

Once Ray has completed her notes about the care and the multiple health authority required forms, she then needs to start the documentation required to begin home supports for the client. In this account, Ray discussed the templates, forms, delegation of task forms, and guideline sheets that need to be completed to start services:

> There's an email template that I send to home support, that says … that I'm doing an intake for a client, and there's a … special form that I got to fill out that's the intake form for this person, which pretty much just says their name, what their ADLs [Activities of Daily Living] are, what home supports are needed, who the backup person would be, so I'll send that to home support, and then in that email to home support [and] I'll write what the client will need for home support. So I'll say medication administration, support

in the morning and the evening, and then also, because this is a delegation of tasks, I need to hand in two forms that are delegation of tasks form. I need to send in a delegation of task form, along with this email, and also a delegation of task referral, so it's two different forms, but pretty much what it says is that I delegate the task of administering medications to the home support team, and I need to give clear rules, because the whole point is that home support team members, they're not there to critically think, they're there to do the task. And so I need to do the critical thinking and say, "Okay, this client needs medications in the morning, in the evening." It gives instructions,… so it's a delegation of tasks and they're also called – PAGs … it's a procedure guideline,… so it's already pre-written. But then there's some weird tasks; we need to write these up ourselves, and … one, I would just fill in on this prefilled form, like how often per day, morning, and evening, and then I would say, "Okay, make sure," and then anything to look out for, I would say if the client doesn't have medications available or if the client refuses more than twice, some medications.… So that's the delegation of tasks that I would also send in the email.… And now I go to another application [electronic health system] called PARIS,… and make a home support referral. [That] is one thing that I need to do,… another thing … is to go to the home support section, and I need to create … the number of hours that I'm referring to that person, … there's again math equations like time.… I get the amount of hours that person is now entitled to that I'm entitling them to, and then I would update PARIS…. And then that's it, and then I would wait, and then home support would probably email me back saying I forgot to do something, and then I would fill that out.

As Ray identified, there are multiple forms as well as systems applications that she uses to create a referral to request for a home support worker to assist this client with their medications. In order to start this task, because of the scope of practice of nurses and expectations of the role for home support, nurses are required to enter very detailed and specific information on the forms; as Ray says, they must complete the "critical thinking" for the task and write it out before it can be delegated. Flipping between email, online templates, inserting verified signatures, electronic systems, and printing, copying, and scanning pages the work of requesting medications to be administered to the client takes time and significant focus to ensure all of the papers, forms, check-boxes, and wording is correct and complete.

Home support workers have distinct work that they carry out with clients; however, there is a similar circus of scheduling, negotiating which clients they will see, identifying and following up on the tasks to carry out, documentation, and communication of concerns and care. The forms nurses complete in the delegation and for establishing home supports are then taken up into the computer systems and the work is assigned to home support workers through supervisors and structures within the health authority.

Referrals and Follow-Up

Documentation of the care provided is only one part of the follow-up that nurses complete after their home visits. In addition to documenting on PowerChart, they may also communicate with family, complete referrals, and send communications to other care providers including physicians, nurse practitioners, other home care providers. Referrals may be paper forms or completed on electronic systems, some referrals, such as to physicians, may be completed on the electronic documentation system then printed off and faxed.

District nurses, those responsible for clients in a geographic area, also have work to complete for the management of home support for their assigned clients. If their clients are not assigned to case management, then the nurses are responsible for the referrals to home support, the documentation and follow-up with home support on any issues that the home support workers encounter in their visits with clients. A lot of this communication occurs through email. Jen discussed the challenges of the use of email with home support staff:

> What becomes kind of problematic is you just get these emails and sometimes it's like, "Okay, well, what do you want me to do about this?" or "Okay,… I have three other questions to ask you before I know what I need to do with this." And so I found … it is difficult because it is not a very engaging form of communication.… It is not very appropriate to be sending these things through email because there needs to be a dialogue, and I think that previously, when we would get phone calls, it would be a lot easier to be like, "Okay, what about this?" And then … you would be able to … you know that sometimes you need to ask these focused questions that other people wouldn't have listed this information unless they were asked, but it is very important to understand the full situation.

District nurses have additional tasks as they must manage clients assigned in their geographic areas. One district nurse identified challenges with the volume of emails from home support staff and shared a story about the type of communication received:

> It's great that the CHWs [community health workers] are sending information, but a lot of them are [say], "That's not our job you should contact the family" or … some of them are like, "This patient is ill." They need to contact the doctor if … [they don't] know or go to the hospital. Some of them … you're like, "They need to go to the hospital," so you

> call them or talk to the supervisor, although the supervisors are usually pretty good about sending them to the hospital if it's something that needs to be done. But … some of them I don't need following up, but there's definitely some that do, so if it's any like pain issues, if it's any wound care stuff, open wounds, that sort of thing, definitely a lot of what we do.… But I've had some where it was a client, she has mental health issues, and I guess she has a cat and her place was filthy, but she'd leave her door open, and I guess a raccoon came into her suite and I got an email from a CHW saying that there was a raccoon in the suite, and I'm like, "I don't know what you want me to do about that." That's not like there's things like that where you're like, "Okay." (Kim)

The work of referring and communicating care needs involves documentation and different approaches for different providers, such as faxes for doctors, emails and forms for home support, and phone calls with families and other home care staff. The referrals, communication, and care coordination that nurses complete takes time and the ability to navigate multiple systems.

Determining the Next Visit

Once documentation of care and referrals are complete, the nurses schedule the clients for their next visit. Determining when the client is going to be seen next involves nursing judgment and decision making. For palliative care clients, some nurses identified that they use a decision support tool to assist in determining the next visit. For clients receiving wound care, the wound care plan that the nurses create may help to determine the next visit, and often they decide this based on their clinical judgment. In both the larger centre and smaller centre, the work for establishing the next appointment for the client is completed when the nurse returns to the office. The nurses then need to communicate the next visit time to their colleagues. They will put the

client names onto the electronic systems either using Microsoft Outlook and/or Excel spreadsheets, depending on the office, indicating what day the client needs to be seen next. Client label sheets and physical charts are also moved into the binders under the date that the clients are due to be seen. At this point, the nurses would also file the physical clients' charts back and close their PowerChart files for the day.

How Nurses Identify Their Work

When discussing how she identifies her work, Kim stated, "We're a jack of all trades, honestly. Like there's so many different skills and scopes and things that you do." Although many participants identified that their work is a little bit of everything, multiple participants noted common priorities within the home care program, including palliative care, wound care, and organizing home care supports. Common descriptions are used to explain the priorities and the purpose of home care, including keeping clients out of hospital and improving self-managed care. Ray stated,

> [The purpose is] to keep them healthy at home or manage them when they've been discharged. And …[to] support clients in different ways at home, so that we can…, in a perfect world, keep them out of the hospital system.

Pat also described these priorities with similar language: "One of our goals is to support and teach clients to self-manage their care as much as possible.… One of the things was when you first admit is planning for discharge." Nurses detailed these priorities in the descriptions of their work and, although the nurses could not identify where these purposes come from or are written, the participants shared the same priorities and purpose.

In summary, nurses view their work as varying with a distinct purpose to support people to be at home. Nurses emphasized the notion of keeping people from being admitted to hospital as an important part of their work.

Conclusion

The complexity observed in the day-to-day work of home care nurses is heavily influenced by institutional procedures and guidelines. The institutional coordination begins from the time that nurses arrive at the health units, use their swipe cards or key fobs to gain access to the locked public building, and sign in on time sheets to receive their pay and be marked present for safety and security requirements, and these relations that are ruling their work continue through the day until the moment they leave, signing out of their computer systems and returning files from the day’s work. When describing the coordinating work to establish his plan for the day, Bob explained determining which clients will be seen, in what order, and for how long, as well as collecting supplies and information to provide care are essential and chaotic parts of the morning and required accessing multiple information systems, documents, policies and procedures, and unwritten rules. Jen shared she is conscious of the need to ration her time and how to manage the morning work, balancing it with the need to get out and see client to provide care, knowing that when she returns to the office, the aftercare work is significant, as she must complete her notes, make referrals for follow up, and communicate and coordinate care for the clients. Kim discussed the corporate orientation of managing costs and working with clients to ensure they have the supplies they need to provide wound care. While Bob and Jen both spoke to the work nurses also complete for the health authority to ensure that clients have service agreements, calculating rates for payment and hours of service that clients can have to ensure they have supports they need to be safe in their homes. Kim described the nature of the work

travelling independently to clients' homes as a benefit to her work as an autonomous practitioner, yet this also has impacts on the emotional work of connecting and developing relationships with clients, as Bob noted the implications for safety for the client and nurse. Ruth also spoke to this in her account of feeling unsafe in a client's home. The hybrid documentation processes result in extra time and work for nurses, and, as Jen stated, there is a lack of trust that the information they need is where it is supposed to be, so sticky notes and hand-over conversations are used to make up for the gaps in the systems.

The descriptions in this chapter identified the flow of home care nurses' work from organizing, collecting, decision making, and prioritizing to go see clients, providing the care, and returning to document, communicate, and coordinate, as described by the nurses and observed in their work. Nurses' work is a combination of the direct provision of care to clients as well as a significant amount of time and energy in the coordination of care. What is not represented in these accounts is the view of the ruling relations coordinating and influencing their work. Rankin (2017) cautioned IE should not remain at the level of the description of work, the analysis of IE must shift the gaze upward to uncover the ruling relations affecting the work of nurses. The analysis of the ruling relations and explication of the trans-local organization of work follows in Chapter 5.

Chapter Five: Findings – What Counts When Counting the Itinerary: Translating Nurses' Work into Abstract Representations

In this chapter, I present the analysis of processes and texts to identify the ruling relations and show how these influences are directing the day-to-day work of home care nurses. Building on participant nurses' accounts of their practice from Chapter 4, I include the voices of the second-level participants,[5] integrating accounts from home care nurse leaders Tara, Sandy, and Jason (all pseudonyms) to the discussion. I refer to the second-level participants as home care nurse leaders. To start this chapter, I identify the problematic as a focus for this inquiry and how I established this focus in relation to particular home care documentation practices. I explore the contradictory uses of the home care itinerary form by exploring the work-text action and explicating the social organization of the itinerary and coordinating policies. I describe how nurses use the home care itinerary form in their day and the work sequences and identify organizing influences in the work of nurses. I detail how the health authority uses the itinerary to abstract data to inform planning and create a simplified view of home care nursing. I show the discursive links to ruling relations and discuss the texts and policies, much of which is hidden or rendered invisible from the nurses' view, that are coordinating nurses' work. For instance, analysis of the texts and actions uncovers how nurses' knowledge, decision making, and skills are subverted by the institutional focus on counting client visits and safety ratings. This chapter finishes with an exploration of these influences and the challenges that arise for nurses like Jen and Bob, whose work is organized by documents and electronic documentation systems used in

[5] Second-level participants in this inquiry are nurse leaders in the home care program. The leaders are all registered nurses who have roles that include managing staffing, reporting on and managing budgets, education, orientation of staff, addressing complaints from clients, and working with staff conflicts.

their practice. I show how the texts used in practice are derived from provincial policies and regulations and how these policies enter into the everyday work of home care nurses.

The Itinerary Form – Contradictory Understandings of Purpose and Use

The itinerary form, a text used every day by nurses, is an analytic focus for this inquiry. As described in Chapter 3, I listened to nurses as I observed their work, reviewed the interview transcripts, highlighting processes, texts, and phrases that stood out. As nurses spoke about their work, they repeated key phrases, including “in a perfect world ”(Bob & Ray), “the good nurses” (Jen), “I don’t know these things” (Ruth), and “for whatever purpose they need it for” (Bob). These phrases illuminated areas of concern, where nurses are completing work that is different than what they idealized as what “ought to be done.” The morning organizing, or “circus” as Bob described it, was an instance when tensions arose between what needed to be done, what is done, and how it is recorded or not recorded for the health authority in everyday nurses’ practice. Nurses commented on the morning work, stating that things could be better: “We’re worried things will be missed” (Jen), and “I’m glad you are here to see this” (Ray). According to Rankin (2017), identifying and articulating the problematic results in a scaffold through which analysis occurs. The statements by nurses identifying their concerns and observations of home care nursing practice and management focused my gaze onto the nurses’ work of morning organization, specifically the itinerary form as an analytic focus for this inquiry.

Every nurse participant identified that they completed the itinerary form as a part of their morning work; however, participants shared different understandings of why they were completing this form and how it was used by the health authority. This difference in understanding and the consistent use of the form opened a line of inquiry into this authorized text, the itinerary form. The analysis of the sequence of actions led to the completion of the

itinerary, what happens with the text after nurses complete it, and the identification of the policies that influence the creation of the form that shows the coordination from local to extra local of the work of nurses.

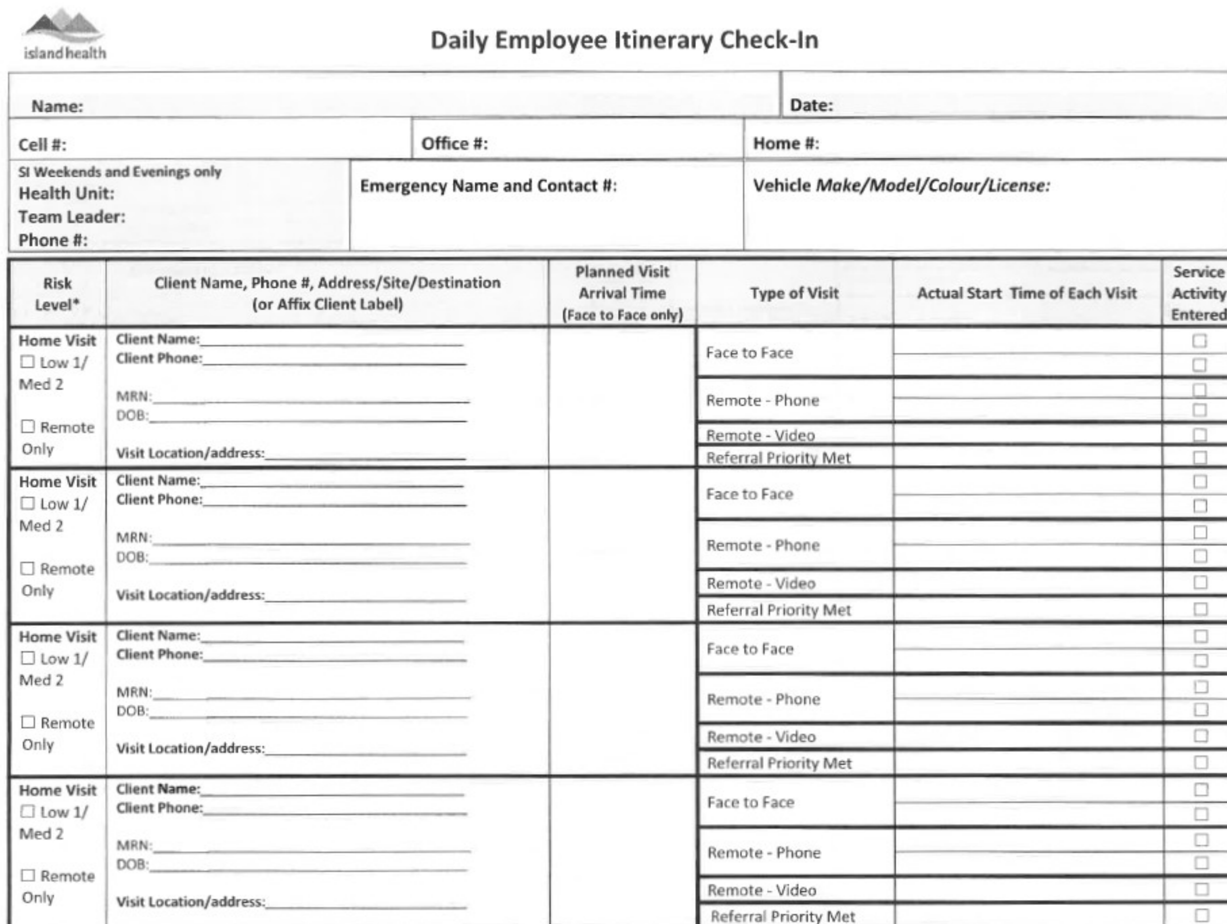
In summary, the itinerary form is a coordinating text that is used across locations in the health authority and influences home care nurses' everyday work. I explore the form further in the next section.

What is the Itinerary Form?

The itinerary is an 8- by11-inch paper form entitled "Daily Employee Itinerary Check-In" (see Figure 5). The information on the itinerary form includes the employee name, date, contact information, client information, including risk level, and safety risk from the Staff Safety and Awareness Planning (SSAP) assessment. Information about each client visit is recorded on the document with the planned visit time, type of visit, and actual start time of each visit. Nurses complete multiple itinerary forms, depending on the number of clients they provide care to. Nurses may also have different itinerary forms as there is one page used for clients who have a safety risk level of low (1) or medium (2) and another page is used for clients who are identified as having a medium (3) or high (4) safety risk. The information recorded on the itinerary forms is identical except for the safety rankings.

Figure 5

Daily Employee Itinerary Check-In



island health

Daily Employee Itinerary Check-In

Name:		Date:
Cell #:	Office #:	Home #:
SI Weekends and Evenings only Health Unit: Team Leader: Phone #:	Emergency Name and Contact #:	Vehicle *Make/Model/Colour/License:*

Risk Level*	Client Name, Phone #, Address/Site/Destination (or Affix Client Label)	Planned Visit Arrival Time (Face to Face only)	Type of Visit	Actual Start Time of Each Visit	Service Activity Entered
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only	Client Name:____ Client Phone:____ MRN:____ DOB:____ Visit Location/address:____		Face to Face Remote - Phone Remote - Video Referral Priority Met		☐ ☐ ☐ ☐ ☐ ☐
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only	Client Name:____ Client Phone:____ MRN:____ DOB:____ Visit Location/address:____		Face to Face Remote - Phone Remote - Video Referral Priority Met		☐ ☐ ☐ ☐ ☐ ☐
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only	Client Name:____ Client Phone:____ MRN:____ DOB:____ Visit Location/address:____		Face to Face Remote - Phone Remote - Video Referral Priority Met		☐ ☐ ☐ ☐ ☐ ☐
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only	Client Name:____ Client Phone:____ MRN:____ DOB:____ Visit Location/address:____		Face to Face Remote - Phone Remote - Video Referral Priority Met		☐ ☐ ☐ ☐ ☐ ☐

In the following account Jen described the itinerary form, how she used it for organizing her clients' care to make notes about client care needs, and what she needed for supplies during her visits. She identified that she records client safety scores on the form and how the safety scores are used to identify potential safety issues for monitoring. Jen hinted that she thought administrators of the home care program also use the itinerary for understanding the demographics of the services provided but she is not sure, and does not really know what happens with the information after she records it.

> This is our itinerary sheet.… It has my name on it, my number, the date, the car I drive, my emergency contact. and then I write, or like take the stickers of all of the people I am going to see, and I photocopy that so I leave one copy at the Health Unit.… Also there is this risk level score that we assign, so if I am going to see someone who is … risky there is different coding. So if it is a high risk and I am going in on my own, it is not a two-person visit, I can maybe call admin before I go in and say, "I'm going to be in here for half an hour, I'll call you when I'm out." Then they could know to call me, so it is kind of a safety thing. That is one of the reasons why you will leave it behind in the office. And then we also have this, I think for demographics, to log how many people we see in a day, and who we see.… And then I keep a copy.… For example, on the left side I have written what I am seeing them for, so right lower leg, coccyx, palliative,… I write things like that. And then I will … have written two doctors names down, children's names, … any details, the buzzer, the buzzer number to get into someone's building, so I keep little notes on here as well. (Jen)

The client stickers Jen referred to are pre-printed labels that contain the client information required on the itinerary form; name, phone number, date of birth and MRN. Client label sheets are stored in each district nurse's binder. Nurses pass the stickers on to the home care nurse who will be seeing the client that day as a way of assigning the clients. The list of clients the nurse is seeing that day is established through their morning work, when they determine which clients they will be visiting, establish the priority for visits, set the time for visits, and identify the type of visit, as described previously in Chapter 4. Once the nurses have their client list and priorities, they peel off the stickers for each client and place them on the itinerary form.

In addition to recording their list of clients and visits for the day, nurses explained that they use the itinerary form to take notes for their client care:

> I normally write if I need to bring supplies. I kind of make a little note at the bottom of the supplies that I need to bring, and I'll write just for why. I usually know why I am seeing the person, but I could write like "dressing, antibiotics" or whatever, and that information like the supplies to bring and what I'm going for is for me. (Kim)

There is no section on the form for nurses' notes or supply lists, but nurses say they find it helpful to write that down and so they use the form to add extra notes.

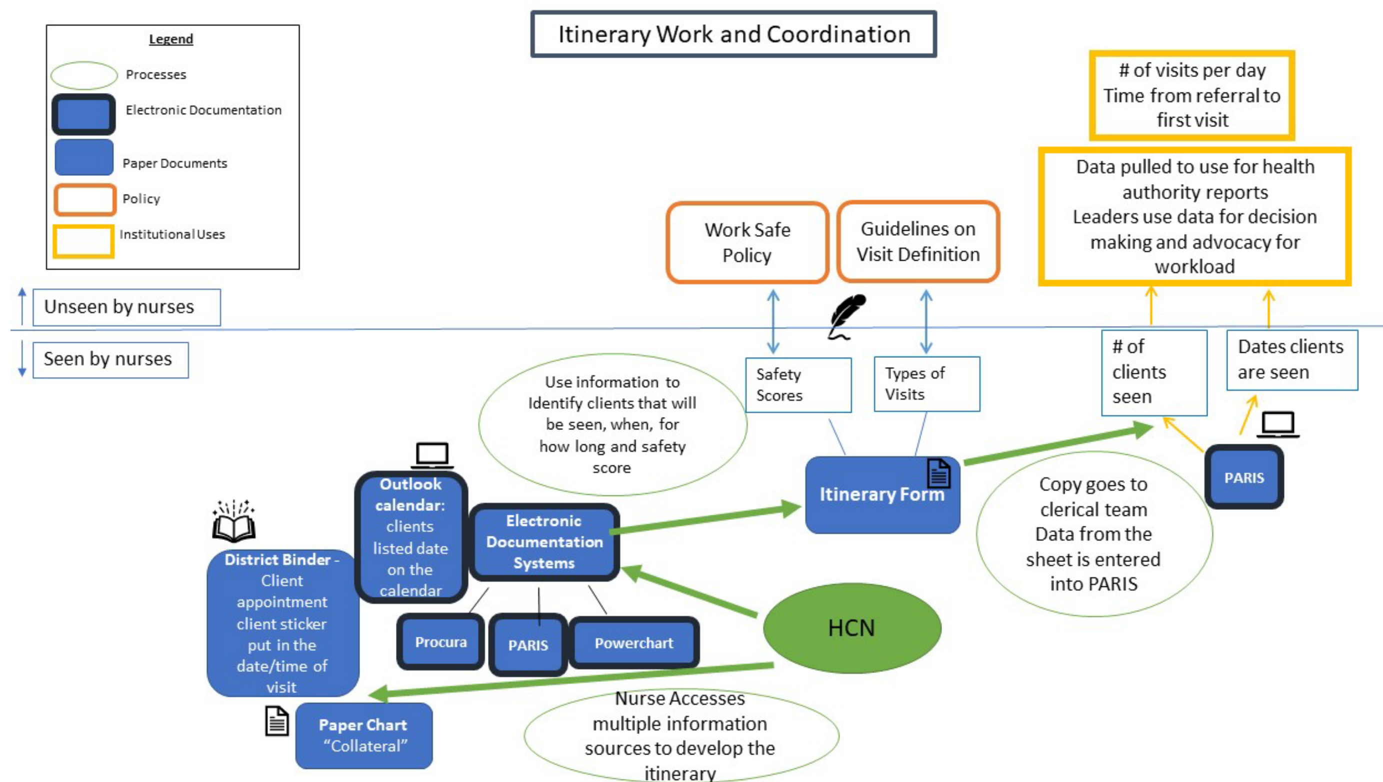
In summary, nurses use the itinerary form to help record their client list, the care needed, and the schedule for their day as well as notes for their planning. In the next section I discuss how nurses complete the itinerary process.

Completing the Itinerary Process and Text

In order to complete the itinerary process (see Figure 6), nurses must do substantial work, use documentation systems, and access and update information on paper charts. The home care nurse accesses information from documentation systems and paper charts, indicated as blue boxes in Figure 6. The information on the documentation systems is used to identify which clients will be seen and to determine the timing and duration of client visits. The itinerary form requires nurses to complete specific tasks such as recording client information, determining types of visits (home visit, phone visit) and safety assessments, the form is coordinating the work of nurses. Policies, as indicated in orange boxes in Figure 6, determine the information collected on the form. The results of the information collected include number of visits per day and time from referral to first visit (yellow boxes on Figure 6).

Figure 6

Map of the Itinerary Process



Note. HCN = Home Care Nurse; PARIS = Primary Access Regional Information System.

As a part of their morning activities, every nurse completes the itinerary form; filling out checkboxes, affixing labels, transcribing safety scores (see Figure 7). The itinerary form becomes much more than a 8- by11-inch paper to record the visit information. It is a document that nurses use to plan, communicate, and record their notes. Nurses will add sticky notes to it and include their own notes about supplies and client contact information. As Jen shared, she writes down information on the form that she may need while she is out on her visits, like a client's daughter's name who is visiting or the front buzzer code to get into the building. The form also activates safety processes and is used to generate data for the health authority. However, in looking at what is recorded on the form, the work of decision making, prioritizing,

determining time allocation and visit needs is distilled into checkboxes on the itinerary and does not reflect the complex work nurses are completing.

Figure 7

Close-up Risk Level Checkbox Daily Employee Itinerary Check-In

Risk Level*
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only
Home Visit ☐ Low 1/ Med 2 ☐ Remote Only

At the end of the day, when nurses return to the office, they submit the complete itinerary form to the clerical staff. The staff enter the visit details from the form into PARIS, an electronic

documentation system.[6] That information is limited to the client's demographic details, the type of visit they received, the date of the visit, and the nurse who completed the visit (Figure 8) and becomes the institutional record of the nurses' work.

Figure 8

Close-up Information Added in PARIS Checkbox Daily Employee Itinerary Check-In

Service Activity Entered
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐
☐

Managers access the data entered into PARIS from the itinerary, including referral dates, the referral priority category, and the dates that each client was seen. The data in PARIS are used by the health authority for a variety of purposes that I discuss in the "The Itinerary as a Tool to

[6] PARIS stands for Primary Access Regional Information System. The PARIS information system is a documentation system and repository of client service data.

Objectify Nurses' Work" section below. Nurses spend considerable time thinking and organizing information to establish their itinerary, yet the itinerary form does not reflect that work. The information recorded is a simplified, objectified view that assigns home care nursing practice into categories for measurement and reporting within the health authority. The end-of-day documentation, determining follow-up care, referrals, home supports, and case management are also not reflected on the itinerary form. Representing home care nurses' work as the number of visits per day minimizes the breadth and complexity of home care nursing work as described in nurses' accounts presented in Chapter 4.

In summary, the information nurses are required to document on the itinerary form is informed by Home and Community Care minimum reporting requirements (BC Home Health Standing Committee, 2011) and WorkSafe BC (2008) policy. These policies set out requirements for what can be counted as visits, work, and what the employer must have in place to meet provincial work safety policies. Examining how the nurses and the health authority use the itinerary form reveals how nurses' work is coordinated by policies outside their view and how the itinerary form is used to create a standardized set of data about their work. Creating a representation of nurses' work that is standardized leads to concerns with workarounds and not representing invisible work of nurses—the work not captured by the standardized checkboxes. In the next section, I demonstrate the connection of policy to the itinerary form.

The Influence of Safety Policies in the Itinerary

As previously described, a central purpose of the itinerary form is to track, record, and ensure that home care nurses' complete safety (risk) screening for all clients. The safety information recorded on the itinerary form is limited to the client risk score and is focused on mitigation of risk to promote worker safety. The discourse on safety is focused on protection of

the worker, workplace, and risk mitigation. This is a limited view that does not address safety of clients, safety of care, and elements of nurse safety such as psychological safety. Safety is objectified into a numeric risk value calculated through a process of assessment and categorization on the SSAP tool. Jen described how the itinerary form is used to record the safety risk category of clients and how it triggers different actions for the nurses and clerical staff for safety planning:

> On the bottom there is a legend, it says risk level reference, so low, start-of-shift check-in and end-of-shift check-out. So that is just standard, like I sign my name in when I start my shift and when I get back to the office I sign. Medium number two … is the same coding, so you check in at the start and check in at the end. Medium number three is … start of shift check in, end of visit check in, end of visit check out. And then high review with leader, staff safety risk reduction plan, start-of-shift check-in.

Jen identified, for each client, the nurses complete the assessment and classification of safety risk based on the SSAP. As Bob shared, nurses do not know what type of situation they may be walking into, as people have varied living conditions and some of these can pose safety concerns.

The client risk score comes from the SSAP tool that is completed on PowerChart. The SSAP tool was developed by the home care education and resource team to meet provincial work safe guidelines that employers must meet and provide to any workers working alone (WorkSafe BC, 2008). To adhere to these guidelines, the health authority requires that an SSAP assessment be completed for every client receiving a home visit.

The SSAP tool consists of a series of questions that the person completing the form asks the client or their family member. These questions include topics such as access to the home,

pets, weapons in the home, access to emergency services, previous violence, and substance use. Nurses will also see a banner alert on the client's PowerChart record that indicates if the client has had a previous violent incident in the health authority. If this violence alert comes up on the computer screen, the nurse records that on the SSAP form as well. When nurses receive a referral, part of the SSAP will have been completed by the intake department; this is a separate department of people who receive referrals and start the computer documentation on clients and then forward it to home care. When nurses receive the referral and partial SSAP, they complete the remaining SSAP questions in PowerChart. The safety risk score is calculated by the nurse and is recorded on the client's PowerChart file. Each day that a client is seen, the nurse who will be seeing the client looks up the safety risk number on PowerChart and completes a checkbox on the itinerary form, confirming the risk score the client has been assigned by the SSAP assessment. As Sandy, a home care nurse leader, explained in this account, the process for completing the SSAP begins at the time a referral is made and is completed by the nurse:

> The initial assessment of the risk in the home and that screening first starts when the referral comes into our community access—phone line or they're our hub, where all referrals come in through, and so they do that initial screening as well, and they'll look in PowerChart see if there's any violence alerts for client or other, … which is how it's indicated. You know, you got "violence patient" or "violence other," and so "other" would be family member or you know roommate.… That feeds the SSAP. The clinician does that assessment, [and] that assessment is shared with home supports as well.… And then it also informs how they do up their itinerary.

As described, the safety risk score triggers safety protocols. If clients are lower risk, then no additional safety monitoring or mitigation plans are needed. However, if a client is identified

as higher risk on the SSAP, then safety mitigation plans must be completed by the nurses on the PowerChart system. For each safety risk that is identified through the SSAP, a risk mitigation plan must be developed. In addition, if the client has a higher safety risk, there is a monitoring process to ensure the nurse checks in before and after the visit. The monitoring process involves the nurse leaving their itinerary form with administration (clerical staff), identifying when they are seeing the client and when they are expected to complete the visit. At the larger office, the clerical staff set a timer for when the nurse is expected to be completing the visit. If the nurse calls to check in before the timer goes, then they mark the visit as complete and the nurse as having checked in. If the nurse has not called in, then the timer goes and the clerical staff phone the nurse to complete the check in. If the nurse does not reply, this triggers further safety check-in follow-up with the clinical services coordinator and the staff to find the nurse and ensure they are safe, as Kim shared in the following account:

> This itinerary sheet is used by admin to make sure that … they know where we are, if we don't end up coming back they can see around what time we were going to be somewhere, and then it shows the risk level, and if it's a 3 or higher, we do have to call admin to let them know we are safe when we leave, so if it's a 3, we just say our estimated time that we are going to be leaving, and we have to call them by then or they call us. And if it's … a level 4, which is the highest, we have to call before we go in and call when we leave.

Tara, a Home Care Nurse Leader, confirmed the itinerary has a safety monitoring purpose: "It's a safety measure, so if a staff hasn't returned back to the office we have a trail of the clients they were going to see and what time roughly they were going to see them so then we can back track."

There is common understanding between the nurses and the nurse leaders about the safety functions of the itinerary form; however, nurses have different ways of addressing the safety risk score. These distinct uses of the itinerary form are discussed further in the next section.

The Intended Use of Safety Assessment and Actual Use: The Workarounds

While completing the SSAP and recording it on the itinerary form is required for nursing staff who travel out on home visits, several participants identified they have different workarounds for the safety process and shared how they may not follow the process as it is set up.

> It is a bit funny to me because … it says for medium- or high-risk visits to ensure the designated working alone clerk is advised,… so you kind of check in with them a bit more. I don't know how much that function is used, because if it is really *that* [emphasis added for intonation] dangerous, you'd think that you would have a two-person visit. But I was just telling my partner the other day that I think, as home care nurses, we do experience a bit of sexualized violence maybe, like a lot of the time. It is … I don't know, it is just more that I think it is. Like we mitigate those things [sexualized violence] more with behaviour care. (Jen)

During observations with Jen, she explained that unless there is a specific safety flag on the client's electronic file, she marks everyone as a low risk. Other nurses also spoke to this practice of recording clients as low risk to fill out the itinerary form. There is variation in how nurses are using the standardized safety process and also concern that the process is not accurately reflecting their sense of safety on visits. As the analysis will indicate, the element of safety represented on the itinerary form from the SSAP numbers is a limited view that meets

institutional requirements but misses nursing needs and client needs for safety and risk mitigation.

Safety as a Requirement of Provincial Policy

The safety component of the itinerary form is one part of the health authority's requirements to ensure a safe workplace for employees. Sandy, a nurse leader, identified that the SSAP tool is part of the working alone guidelines and policies influenced by WorkSafe BC (2008). In fact, the itinerary and the SSAP are informed by the requirements of the provincial work safe policies for people who are working alone (Island Health, 2020a). There is a direct use of language and process from the WorkSafe BC policy on the itinerary form. For example, WorkSafe BC (2008) Occupational Health and Safety Regulations Part 4, General Conditions, state employers must identify hazards and take steps to eliminate the hazard or minimize the risk before a worker is assigned to work alone. The SSAP tool also uses the same language from the WorkSafe BC policy; as an example, when identifying hazards and mitigating risks, nurses are asked if there is a risk to create a "mitigation and safety awareness plan to reduce or eliminate the risk" (Island Health, 2020a, p. 3). The WorkSafe policy also required employers to develop and implement a check-in process for the workers assigned to working alone and establish a procedure for time interval for check ins and provisions for emergency rescue (WorkSafe BC, 2008). The check-in process and procedure that is triggered by the safety ranking scores recorded on the itinerary form and discussed by the nurses occur as a result of this policy. The requirements outlined by WorkSafe BC are integrated throughout the safety assessment and documentation process for staff, including the need for a phone-in system, time checks, and violence prevention. The language of risk and mitigation is used by nurses. As Kim shared when discussing the check-in process, "You ask safety questions," and then if there are risks, "you

look at how to mitigate the issue," and then if "the risk level is 3 or higher we have to call admin." Nurses spoke about risks, mitigation plans, and risk scores triggering safety monitoring processes, and the words and processes that they referred to came from the WorkSafe BC (2008) policy and SSAP tool.

Safety is also identified in the provincial *Home and Community Care Policy Manual* (British Columbia Ministry of Health, 2019), which stated health authorities can approve home care services if the client meets specific criteria, including "the client' behavior and/or home environment does not jeopardize the safety of the community nursing staff. Potential risks have been assessed and any necessary risk mitigation strategies can be successfully implemented" (p. 1). The language in these two policy documents are repeated on the SSAP and itinerary form that nurses complete. The policies reflect the value of risk management, whereby the worker is responsible to identify the risk and mitigate it.

While the health authority is meeting the legislated obligations from WorkSafe BC (2008) and the Ministry of Health provincial policy (British Columbia Ministry of Health, 2019) through the use of the SSAP tool, the nurses' experiences of safety when completing independent home visits is not accurately reflected in the itinerary tool and connected processes. Ruth identified a home visit in which the safety risk recorded on the SSAP and itinerary did not match the risks she experienced. Ruth was seeing a client for wound care; the client had dementia, and during the visit he exposed himself to her and made inappropriate sexual comments. She stated that she redirected and set limits for the behaviour, but this experience was impactful for Ruth, as she described the feeling of not being safe in the home:

> None of that was on his Staff Safety Assessment Risk form, so when I went back to the office I had to update it and then I, he gets home supports, so I sent it to the home

> supports as well to update them. And then I came home, and I thought, "Ahhh, it's been so long. I need to take martial arts again." So I signed up for Martial Arts. (Ruth)

Ruth goes on to identify that she is "safety oriented" and so she is "always thinking" about safety and an "exit plan." She shared stories of coworkers who had been assaulted by clients or bitten by dogs and how she then documents clearly "no visits after dark" or makes notes about safety issues. In contrast, Jen stated, "I don't always prioritize my own safety." She discussed a situation with orientating a colleague to a higher risk setting where she was comfortable based on her past experience working with clients in low-barrier settings who actively were using street drugs. Jen shared, "There are definitely nurses and people who have like just a higher threshold for those things, and whether that is a good thing or not that's a good question." Jen identified that two-person visits are an option but it is "loosey goosey" on how to get a two-person visit established. Jen added that requests for two-person visits are taken seriously and supported when nurses ask for assistance, but she sees these risks differently than other nurses. While the SSAP tool and documentation on the itinerary form provide ways for the health authority to meet their legislated and policy requirements for safety, there are risks that nurses experience and client safety perspectives that are not captured in the SSAP process.

Also missing from what the nurses check off on the itinerary form and the SSAP is a perspective on client safety. Clients may be asked to come into the clinic setting to receive care because of the assessed risk of safety in their homes. Bonnie shared,

> [If] we feel that they are more appropriate for the clinic, and we also have people come to the clinic … [because] their house isn't safe. So, whether it's substance use or whatever's happening we know we can't go in there so we ask that they come to us.

The need to protect nurses' safety when working alone is forefront in the WorkSafe BC (2008) policy and, what the client needs, how they will feel safe and supported to receive care, also should be considered. These considerations in planning for client safety and care are not reflected in the risk safety checkboxes on the itinerary form.

In summary, the safety focus of the itinerary form is coordinated by provincial policy. On a daily basis, nurses spend time completing the SSAP, transcribing risk scores for each client, developing and documenting risk mitigation plans, and establishing check-ins for high-risk sites. Yet, there are situations in which safety of nurses is not upheld by these processes and those in which nurses are completing the documentation differently than intended. Boss texts, as D. E. Smith and Griffith (2022) described, are policies and procedures that establish a frame that organizes the work and creates representations in institutional languages. The WorkSafe BC (2008) policy and *Home and Community Care Policy Manual* (British Columbia Ministry of Health, 2019) are boss texts from which language is used and work actions are coordinated. When nurses tick the checkbox for low or high risk on their itinerary form, this reveals how nurses' work is coordinated by the WorkSafe BC policy to create a textual reality that safety is addressed; however, the textual reality, may not reflect the actual experiences of nurses or their clients' needs.

Workload Measurement and Data Generation From the Itinerary

Nurses understand and use the information on the itinerary form in different ways than the nurse leaders. As described, nurses use the itinerary form to plan and record their client visits for the day. However, they do not see how the information they record on the form each day is used to create numerical counts of visits per day and to inform planning and budgeting for home care. Jen shared,

> On the copy [of the itinerary] that is left in the office, I will input the time, the time of the visit, and admin keeps it, and I am pretty sure that they put the demographics into some kind of system … for … health statistics or something.

Similarly, Kim shared that she knows the itineraries are kept but is not clear why:

> They input the visits and around what time we went into a computer, apparently.… They take the hard copy—and I believe they keep them for a year's time … just in case any lawsuit comes up so you can look at what you did that day.

Nurses are aware that the information from the itinerary form is transcribed by clerical staff into PARIS, but they are not clear why it is entered or how the data are used.

In contrast to the accounts of nurses, the nurse leaders who are managing budgets and staffing, identified how they use the information on the itinerary form to inform their work. In interviews, the nurse leaders shared that the itinerary form is used as a tool for safety monitoring as well as to generate data. These data constitute a limited view of nursing work; however, leaders find the information useful when advocating for nursing positions and time as well as for program budgets.

The Itinerary as a Tool to Objectify Nurses' Work

The itinerary form generates data about home care visits for the health authority and the Ministry of Health. The nurses check off and record the visits they are completing each day on the itinerary form and then clerical staff enter this into the PARIS electronic documentation, which creates a repository of data (Sandy, Home Care Nurse Leader). Another nurse leader described the itinerary form as "a way to collect this data [number and type of visit], and our admin entered it into the system so we know how many face-to-face or remote visits we've done" (Tara, Home Care Nurse Leader).

The data are used by managers for staff planning purposes and also used by the health authority in annual reports (i.e., Island Health, 2019) and to report to the Ministry of Health on their performance standards (Island Health, n.d.). Jason, a nurse leader, explained that visits are "logged" through the itinerary form where they are entered into PARIS, and then he can pull data to look at referrals, review client visits, and see which staff are seeing which clients when and for how long. Jason identified that he used the information on PARIS to confirm if a client was seen on a particular day or not and to see how many visits nurses are completing per day. Managers and coordinators use the data to demonstrate to senior management their need for more staff and are required to use this when completing request forms for new staff positions. Jason noted, as a leader, he reviews workload and advocates for more staff and reallocation to make sure "not one person is drowning," but it is a challenge; "You know there's also the subjective.… It's hard to really understand fairness, … someone's 100 percent may be someone's 60 percent.… Fairness is so subjective and it's so hard to measure."

Likewise, Sandy identified that she accesses the data to see "how often a client gets visited either by phone, remote or face-to-face." The data can be used to count client visits and are used to assist with staffing decisions; however, mining the data for surveillance purposes, looking at who was seen when and by whom, is also possible. The nurse leaders all identified that the data can be accessed through reports, but the reports are limited in what they reveal about the nurses' work.

> We can pull up those reports to just see and that's a very small picture. We know clients are very complex, so that's just a very small picture of what you know their caseload might be.… [You might have] someone with a caseload of only 20 but their clients are

> extremely complex, whereas you might have someone with a caseload of 100 with more simple stable clients, so it's very small picture. (Sandy)

Tara, a home care nurse leader, added that there are challenges in the way that information about visits is recorded and reported:

> I actually don't think it's super accurate, the way we track data.… The remote visit, I think anytime you're working on a client you should be tracking that data, not just if you had a 10-minute conversation with them, but now you need to do 2 hours of paperwork on them. That 2 hours of paperwork I feel should be documented as visit time.
>
> I just think we need to note that this data isn't all the information you have to look at—drive time and geographical areas and gas mileage and all that sort of stuff. (Tara)

The nominalization of nursing work into a simple count of visits per day hides the knowledge, decision making, and complexity of home care nurses' work. The metrics generated from the itinerary form are limited and come from the information nurses record to plan their daily work without the nurses' knowledge of how this information is used. The home care nurse leaders all spoke to the limitations of the data they could retrieve. The leaders identified that the need to contextualize the data as the work nurses do is more than a number count of visits per day. However, within the health authority, outside of home care, the visit counts are used to report on the achievements of the program area and are not contextualized. Counting the care that nurses provide objectifies the work of nurses, simplifies the care they provide into a number that is measurable and can be evaluated for efficiency. The visit counts are valued by the health authority to demonstrate how they are meeting organizational targets, business expectations of health care provision. Tara, a home care nurse leader, further explained how available data do not show the full picture:

> Trying to get appropriate workloads for our staff, it's difficult … because statistically when you look at our clinicians caseloads they might not have a higher caseload than, say, a clinician that works downtown, but the difference is we cover such a broad geographical area. So really trying to pull the correct data and make it known so that, you know, the work staff might not look like they have more on their caseloads.… You have to look at the difference, you know? They're just looking at one number versus all of it.

The numerical representation of home care visits and safety meets the needs of the health authority for reporting and recording. The institutional requirements for measurement and accountability coordinate and simplify home care nurse work. The itinerary form creates a textual reality of nursing practice that does not adequately represent the work nurses are completing.

Quantifying Nurses' Work Through the Itinerary – What Counts?

The recording of visits, and what can be counted as a visit, is defined by provincial policy. The Home and Community Care Minimum Reporting Requirements Visit Definition policy (BC Home Health Standing Committee, 2011) outlines what a visit is and what can be counted as a visit. The policy serves as a tool that simplifies the complex work of nurses into a checkbox count, legitimizing for the health authority and province what counts as home care nursing work. D. E. Smith (1987, 2005) identified the practice of abstracting the actualities of work into generalized, objectified, and impersonal counts as ways of governing. The intentional subordination of individual knowledge coordinates the work of nurses across sites and represents the work in a textual reality (D. E. Smith 1987, 2005). The itinerary form is a text that directs, coordinates, and standardizes nurses' work into a count.

What can be recorded on the itinerary form as a "visit" is defined by the BC Ministry of Health. A visit is "an occasion in which care or service is provided to a client or an occasion when clinical direction that influences the care of the client is given" (BC Home Health Standing Committee, 2011, p. 1). The definition of what a visit is "focuses on clinical services to the client" (BC Home Health Standing Committee, 211, p. 1). The *Home and Community Care Minimum Reporting Requirements* (BC Home Health Standing Committee, 2011) defined what nurses can count as a visit. Additional details are provided to clarify what a face-to-face visit is, including direct interaction with the client or caregiver or bereavement care (BC Home Health Standing Committee, 2011). Remote visits are not face to face but must influence care, and some remote interactions may not be counted as a visit if there is no direct interaction with the service provider and the client, meaning that consulting other health care providers, picking up equipment, or dropping off forms do not count as visits (BC Home Health Standing Committee, 2011). Jason, a home care nurse leader, identified that the information from the itinerary form is input into PARIS because "it's a Ministry of Health mandate and … so we log each one of our visits and then, and it helps us understand whether a visit was made." The reporting requirements document identifies that "a clearer, standardized definition will result in increased accuracy of service utilization data" (BC Home Health Standing Committee, 2011, p. 1). The visit counts result in a "capture of volume" (BC Home Health Standing Committee, 2011, p. 1) for the specific service types in home care. The standing committee document clarifies that the visitation counts are not intended to measure workload, as that is captured through national management information system using Resident Assessment Instrument data reported to the CIHI (BC Home Health Standing Committee, 2011). However, Sandy and Jason, both nurse leaders, shared they use the data created from the volume counts on the itinerary form to inform planning for staffing

and workload. The type of visit and number of visits recorded on the itinerary form are defined and categorized by the BC Home Health Standing Committee (2011) definitions; therefore, the data recorded and then entered into PARIS result in the information managers use and report on home care nursing work.

In addition to tracking the number and types of visits, nurse leaders also access the data that the itinerary form generates to identify which clinician has seen a client when there is a client complaint. For example, Jason, a nurse leader, shared that when there is a concern from a client about not receiving a phone call or care, he can access the documentation from clinicians on PARIS or PowerChart to confirm if they received a visit or not. Sandy, a nurse leader, identified she also used the data during COVID-19 restrictions, as she was able to look up and see which clinicians saw a particular client during their infectious period to notify them of their exposure.

The minimum reporting requirements from the BC Home Health Standing Committee (2011) is a boss text that directly influences what information nurses are able to record on the itinerary form and influences what is counted as a "legitimate" visit. The counts of the number of visits that are recorded from the itinerary are used by leaders to inform planning for staffing and by the health authority to represent the work of home care.

Examining the itinerary form and its uses highlights what is missing in the text and data that are generated from the use of the form. The coordination of care, morning circus, establishing home supports, referral, and follow-up processes that take hours of time and effort by nurses are not reflected on the itinerary form. Additionally, the length of visit, the complexity of care, decisions made, and the care provided by clinicians are not reflected on the form. The broader view of nursing work is not captured in the itinerary form and subsequent reports that are

created from the data on the itinerary are limited. This absence has concerning implications for nurses whose work is then not fully articulated, seen, or valued. In one example Tara, a nurse leader, identified how the itinerary and what can and cannot be counted does not match the time nurses are investing into their work:

> They rolled out the new itinerary.… It noted that dropping off paperwork wasn't considered a visit, and I was like, but you're driving out to the person's house, you're seeing the person, you're dropping off the paperwork or getting them to sign the paperwork, having to drive back—that should be part of the statistics because that takes up part of your day, but it isn't considered a visit technically. But that to me was really interesting cause I was like, well, how are we capturing all the data then? And that really is where funding all this stuff comes from is they want to see the numbers, right? The number of clients and, you know, that's another piece, they're not looking at the complexity of the client. Like … a clinicians got 50 clients on their caseloads, but… maybe three of them need to be seen every single day, so that's three people on your caseload that you're seeing every single day, where another clinician might a few more on their caseload and a ton of them.… You're only doing a once-a-month phone call check in,… so that's where it doesn't take into account the complexity of the clients you're seeing; it just takes into account the straight number that you have on your caseload.

The narrowed view of recording what a visit is based on the BC Home Health Standing Committee (2011) definition and using this to provide a count of clients seen is an issue for the home care leaders. Nevertheless, the count of client visits resulting from the itinerary form is used by the health authority. For example, in the 2019 annual report, Island Health identified

1,092 client visits and 8,201 home care hours per day are delivered inclusive of all home care providers. This numerical count was used in the Island Health (2019) annual report to provide an overview of the types of services that are being offered in the health authority each day. In another example, the information available on the BC Ministry of Health (2021) website for the *Home and Community Care Data Set* is “information on transactions for individuals receiving services” (para. 2). The data available are the recorded counts of visits, locations of visits, and anonymized client demographic data. The home care nurse leaders spoke about the importance of contextualizing the information generated from the itinerary forms. When the data are extracted and used at a health authority level in reports, the intended meaning of what counting visits per day means and what is missing from these values is not presented.

In addition to the limited view of visits per day, the health authority has a myopic perspective of service performance for home care. The time between a client referral and service initiation is the only metric provided on the *Island Health Performance Measures Home Care Professional Services* (Island Health, 2021). This one metric limits the view of home care “performance” to the measurement of time between referral to first contact. Although this value is important to have service provided in a timely manner, it again limits the understanding of the impacts and value of home health nursing. The emphasis on responsiveness to the referral is identified as a checkbox on the itinerary form, a “referral priority met”; however, the nurses in their interviews and during observations did not complete this checkbox or discuss it. It is not clear why nurses are not completing this checkbox, but the presence of it on the form links directly to the performance standard. There is an ability to determine the time between referral and visit from the data in PARIS.

In summary, reporting requirements for home health and the use of visit counts are a narrow view of the complexity of home care nursing work. The current Island Health (2020b) service plan includes home care services targeted for change, "increasing access to home and community care services for seniors to improve their outcomes and reduce avoidable emergency department visits and hospitalizations" (p. 10). The performance measure identified for this change goal is the number of people with a chronic condition being admitted to hospital with the aim that this will decrease because of increased access to home and community care. The focus on this strategic improvement from the health authority perspective is solely on prevention of admission to the hospital. This narrow view blocks out the impacts of home care nursing work on the care, health outcomes, and the lives of clients receiving their care. Much like a horse with blinders on, the view of counting admissions and visits and measuring the time between referral, intake, and first visit blinds the health authority to the impacts home care nursing has on the care of clients and the health of the population.

What is Not Seen – Does it Have Value?

Critically examining the itinerary form has identified what is reported to the health authority and shined the light on conflicting values. The health authority values concrete numerical figures to inform planning and evaluation of services and safety. The safety ranking numbers are used to meet policy requirements for risk management and mitigation. The emphasis of objective data is reflected as the itinerary form is activated daily to record and report data. What is not seen in the numeric data is the work nurses conduct to produce the distilled representation of their work on the itinerary. This work includes the navigation of multiple electronic systems that the health authority has implemented for electronic documentation and tracking. Each of these systems captures different data with unique purposes and uses. From the

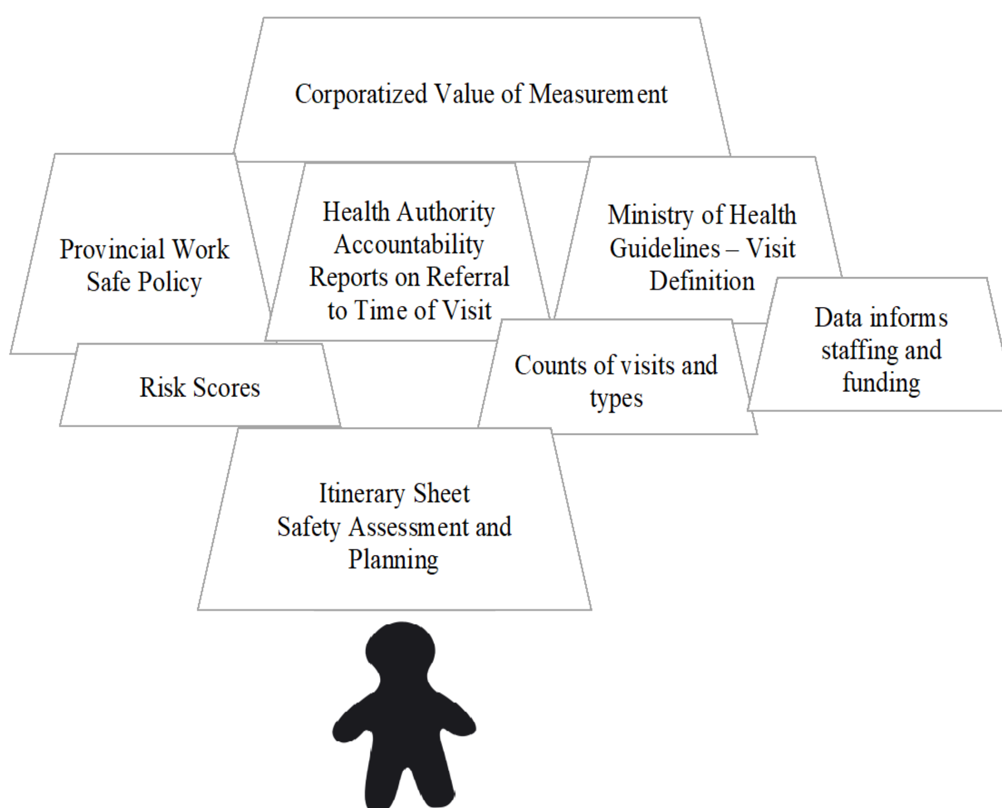
nurses' view, accessing these systems is necessary so they can retrieve information about their clients to be able to inform their care, determine supplies they will need, develop and update care plans, communicate with colleagues, manage care for clients, and document the care they provide. Once nurses have the information, they engage in decision making about priority, length of visits, and how to organize their visits for the best travel flow and timing. The safety assessment questions completed by nurses are driven by provincial mandates, and the value of these to the organization is embedded in the requirement of these assessments and recording of the safety mitigation plans and rankings on the itinerary form by care providers. D. E. Smith (2006b) identified the standpoint of participants and the interaction with the socially organized relations in a small hero diagram, in which the nurses, the small heroes at the bottom of the figure, interact with the overlapping influences identified in the boxes above them. Figure 9 depicts the nurse at the bottom of the diagram, entering into the institutional influences through their work. As the nurse completes the itinerary form, the information being generated—the risk scores, counts of visit, and types (Figure 9)—are visible. However, the policies informing the work are invisible (Figure 9 – WorkSafe policy, visit definition guidelines). Additionally, the invisible influences are connected to larger policies and practice within the health authority and the province.

The morning work of nurses organizing their plans for client care is complex and is directed by ruling relations of the organization. In analyzing how nurses use the itinerary form and how it is used by the health authority, I found direct linkages to provincial policy for workplace safety (WorkSafe BC, 2008) and the BC Ministry of Health (2019) requirements for reporting care provided that reflect the health systems requirements for measurement, evaluation of efficiency, and a managerial turn in systems that value corporatization of health systems as

businesses-generating impacts and outcomes. The values of the New Public Management era, such as efficiency, reducing spending, time constraint, and performance measurement (Strandås et al., 2019) are inserted within the itinerary form and enter into the everyday work of home care nurses, impacting how nurses establish and organize their work each day, determine priorities, and identify and speak about safety issues.

Figure 9

Small Nurse Hero



Nurses identified how they adapt their itinerary plans based on the needs of the clients and how the day unfolds. When there is a traffic delay or a client in crisis, the nurse adapts on the spot to the needs and makes their schedule work. When a client wants to talk longer about their diagnosis or fears about pain while dying, nurses take the time and stay with clients to address these important questions. Bob identified that often visits can go “sideways and issues come up

that weren't expected, and the 30-minute visit is no longer that timeframe, affecting all of your next visits." This means the nurse may be late for their next visit or may miss a break, but this is the work they do to adapt their plans on the go. These changes are not recorded on the itinerary form submitted to the clerical staff for input. As Jen identified, there is a culture about time for visits, and 30 minutes is the standard block used to book visits unless it is a new client or a palliative care visit. These norms influence how nurses schedule their time on the itinerary and their planning for the day. Time is a limited resource for nurses, so their plan is adjusted, and skipping a lunch, bumping their next visit times, and working late are what nurses do to make it work so they can return to the office and do their end-of-day work.

Bob noted the complexity of coordinating ongoing care for clients and talked about how client care is managed in his geographic area, including the volume of communication and emails, paperwork, referrals, and support for caregivers. Ensuring follow up on home support concerns, referrals to other care providers, and communicating with families is central to the work of home care nurses. This personalized accounting and planning can only arise from getting to know one's clients, the families, their contexts, and the context of the nurses' overall group of clients as well as the team of nurses working at any time, work that cannot be reflected on the count of visits each day generated from the itinerary form. As one nurse shared, the visit may be 30 minutes, but the paperwork back at the office can be 2 hours (Tara). As I was observing nurses, I saw them come to each other and ask about how their day was looking, if they needed help, or were managing okay. In the supply room in the morning, as nurses moved around the room collecting their dressing kits and assembling their bags of supplies, they would ask about the progress of clients and seek advice from each other. One morning, a nurse who was accepting additional visits to help a district nurse went to that district nurse and asked how the

client was when the district saw them yesterday and if there was anything extra she should take or do. I observed nurses helping each other when they had clients with difficult situations, offering to take other clients so the nurse could complete their paperwork, communication, and referrals with the complex client. After the morning huddle call one morning, a group of nurses who were working in the district that day came together to ask who was best to see which clients, who had been there the day before, who needed to not see a particular client that was having some difficulties that day; they planned together to determine the clients they would see and how they could help each other out. There was a sense of camaraderie in the health units I observed as nurses sought to manage and share the workload. This understanding among nurses and the desire to help out and balance the workload is not reflected in the measures of client visits on the itinerary form.

In conclusion, this chapter included textual analysis of the itinerary form and the use of the form as a part of nurses' work. There are distinct differences in how nurses use the itinerary form relative to how leaders in the health authority intend and use it. Examining how the itinerary is used from distinct locations, inside and outside of positions of power, also revealed what is not recorded on the itinerary form and reflected the ruling relations that are directing the information collected. Therefore, findings indicate that the complexity of nurses' work is oversimplified as the health authority extracts these basic elements of data from the form. The language from the WorkSafe BC (2008) policies and BC Home Health Standing Committee (2011) definitions are explicitly and invisibly entering into the work of nurses. By standardizing the nuances of clients and the kinds of training and support for nurses to conduct individualized care, care is refocused on the items on the form. Nurses' expertise, decision making, and knowledge are subverted by the institutional focus on safety ratings and objectifying visits into

counted values. The standardized and objectified counting of safety and clients that come from the itinerary form does not reflect the breadth of thinking, decision making, prioritization, and complexity of nurses' practice, yet these figures are used to represent home care nursing in reports and for planning and funding purposes. The limitations of these processes, ruling relations, and the broader influences of capitalism and managerial practices in home care will be addressed in the next chapter.

Chapter Six: Discussion – Completing the Circle

Home care programs are identified as a critical part of the Canadian health care system (CNA, 2013), enabling those who want to receive care at home to have this option (CIHI, 2017; CNA, 2014). While Canadians desire to have effective home care programs, there are gaps in understanding what home care nursing work is and how it is being socially organized. The majority of professional care provided in home care is completed by nurses (CNA, 2013; Ganann et al., 2019), and nursing work supports people to remain at home through illness, disability, and end-of-life experiences. The purpose of this inquiry was to identify the work of home care nurses and to trace how home care nursing work is institutionally mediated and coordinated. In this chapter, I complete the analytic process of my institutional ethnographic inquiry, reflecting back to my initial research questions in light of my discoveries and in relation to the literature. I specifically discuss how the safety discourse enters into nurses' work and produces accountability for nurses through the home care itinerary documentation. The itinerary form and how nurses use it for planning and accountability will also be discussed as the language and form is used to create measurement and objectified counts of nursing work. The influences of accountability, efficiency, and measurement coming from neoliberal ideologies enter into this discursive practice in nursing, similarly coordinating nursing work. Finally, I present what is missing from the itinerary form and discuss the work of nurses in balancing the needs of the client and the health authority, the organizing work and critically important coordination of care, and the cost of home care.

The Study Questions and Problematic

I began this inquiry with a curiosity about the apparent absence of awareness of home care nursing in the public realm, including media, public information, practice information, and

scholarly literature. The paradoxes of the expanding need for home care with an aging population, greater complexity set against the lack of presence of nurses, and the increasing development of new programs without nursing staff fuelled my curiosity. This led me to question what is happening in current home care nursing practice and to identify what is organizing—and disorganizing—the work of nurses in home care through an IE approach (D. E. Smith, 2003, 2004, 2005, 2006b). I explored the following research questions in this inquiry:

1. How do home care nurses describe their work providing care to clients every day?
2. How do the work policies, processes, and institutional structures, as ruling relations affect nursing work?

From my initial analysis of the data, I focused on nurses' itineraries as a way to explore the problematic.[7] From the standpoint of nurses, I engaged in an iterative analysis to trace and show the coordinating features within the itinerary that was central to how home care nurses structured and spoke about their daily work practice, and the influences of these largely invisible features on everyday home care nurses' work. Nurses' work is not adequately represented on the itinerary form, and this stands in contradiction to the BC Home Health Standing Committee (2011) reporting requirements set out to capture and account for nurses' work. The assessment and planning work of nurses, the decisions and knowledge guiding them as they established their daily itineraries, and the plans for client care are not represented in the itinerary form. What is recorded on the document includes standardized rankings of safety risk, types of visits completed, and planned time for visits. As established in Chapter 5, these standardized

[7] *Problematic* is a methodological term used in IE that identifies the puzzle, the areas of tension between lived experience and social organization, in which the researcher can engage to identify and analyze how social organization is influencing the work (Allen, 2015; Bisaillon & Rankin, 2013; D. E. Smith, 1987).

documentary representations create an incomplete view of home care nursing, informed by policies that, in turn, shape decision making for and understandings of home care. Nurses use the itinerary form to plan their care and record their daily plan. This use of the form differs from how the nurse managers and decision makers in the health authority intend the form to be employed as a safety tracking tool and for other uses of the information recorded on the form. This difference intended in the use of the itinerary is fundamental to the problematic and this textual analysis of how the itinerary and policies are employed in home care nurses' work. The subordination of nursing work into nominalization through the itinerary checkboxes engages home care nursing into a managerial focus on measurement, efficiency, and accountability. The data from these checkboxes establishes the allocation of resources in home care and, therefore, how this text represents home care nursing work is important.

Nurses engage in complex work from the morning circus of meetings, assignments, distribution of supplies and schedules, through to the unseen work of providing direct care to clients in their homes, to the end of day coordination and documentation of care. Home care nurses' work is embedded in systems of care where nurses regularly navigate between health and social systems, meeting care needs for clients and caregivers. Nurses provide direct client care such as wound care, medication administration, teaching, assessment, and referrals and critical work of coordination, communication, and advocacy. From the moment nurses arrive at their places of work until they leave their work is socially organized. Nursing practice is ruled by processes, policies, and multiple electronic documentation systems (Campbell & Rankin, 2017). In the analysis of the itinerary form in Chapter 5, I identified specific connections to policies for safety and measurement of work. The policies and process traced in Chapter 5 to the WorkSafe BC (2008) policy and BC Home Health Standing Committee (2011) minimum reporting

requirements as boss texts show the connection to the New Public Management era of managerialism, efficiency and measurement and safety discourses (see Figure 9 in Chapter 5). Terms such as risk mitigation and low-risk or high-risk visit are used regularly in nurses' planning and discussions with each other and their managers. These terms are also present on the itinerary and originate from the WorkSafe BC policy. It is important to identify these ruling relations and the dominant institutional activities that are shaping and present in nurses' everyday work practices, subordinating their knowledge and experiences, and to make visible the sites where change is possible (D. E. Smith, 2005; D. E. Smith & Griffith, 2022). Safety is also a ruling relation in home care nursing work, which I discuss in the next section.

Safety as a Ruling Relation in Practice

Nurses identified safety as a purpose of the home care itinerary form. Employee safety is highly valued by the organization (Island Health, n.d.). As an example, Sandy, a home care nurse leader, identified how she framed issues in the context of safety as an effective strategy to get action and attention on particular needs for clients and her home care work. However, the broad term "safety" is narrowly defined in the SSAP assessment and how it is represented on the itinerary form. The routine standardization of the assessment of safety and risk, and transcription of information creates problems for the legitimacy of the assessment process and misses addressing safety issues that nurses identify in their work. This limited view of safety also restricts what can be known about safety for nurses and health authorities and shapes how nurses navigate ethical and practical safety issues in their work.

The aspects of psychological safety for nurses in their practice are missing on the itinerary and SSAP assessments because the policy focuses on safety for workers who are working alone. Psychological safety is not addressed in the narrow view of what a safe

workplace is. As Bob identified, nurses often experience challenging situations, and it can be a struggle to jump in and out of the immersion in people's lives. The unique role that nurses have in home care includes isolation on home visits and providing care on the "home turf" of clients, resulting in additional safety considerations as nurses work to provide ethical care that is guided or aligned with client values. This presents unique challenges in navigating client autonomy and provision of safe care with clients and families (Demiris et al., 2019; Lang et al., 2006).

In my observations, I saw nurses debriefing with each other after visits with clients and their families who were challenging. They shared that they try to connect with each other, but it is hard to do as they often have limited time when they are back in the office to finish their work. One day, I observed Jen and a social worker discussing a plan to meet with a client and provide care moving forward, as they had both worked with this client for a long period of time, given that the client's health was declining rapidly and they needed more palliative services. In this exchange, both Jen and the social worker identified the challenges and joys of having longer term relationships and knowing that the client would be dying soon. Jen went to see the client that day and also had five other home visits for clients with other varying needs that they managed. These aspects of psychological safety and ethical work are missing from the SSAP tool and itinerary form.

Client safety issues are addressed through separate reporting processes within the health authority. These processes are used to identify systematic issues and opportunities to prevent errors and reduce the risk of serious harm to clients. The standardized assessment process (i.e., the SSAP) and reporting on the itinerary form create a textual reality for the health authority that safety is being addressed. The safety assessment is recorded and reported and, therefore, WorkSafe BC (2008) requirements have been met. Standardized checklists that are replicable

across sites and utilized by all staff create a representation of safety that minimizes the actual work that nurses are doing to assess and plan for the client's as well as their own safety (D. E. Smith, 2005). The guise of safety created by these standardized processes misses the breadth of work that nurses do to ensure safe practice and, as heard from Jen and Ruth, this oversight creates the potential for unsafe practices and workarounds.

Assessing safety before going alone on home visits to deliver care is important to ensure that nurses are entering into an environment that is safe for them to meet the client and provide care. As Bob identified, nurses never really know what they are walking into on a visit. The safety assessment process in the SSAP is directed by the provincial WorkSafe BC (2008), the BC Ministry of Health (2019) and BC Home Health Standing Committee (2011) policies, which carry power in ensuring that the health authority has processes in place to protect workers' safety. The health authority is required to ensure there is a process for identification and mitigation of risk because nurses are alone when providing care to clients. The language of risk mitigation is the same on the WorkSafe BC safety regulations and the health authority SSAP form. For example, "risk mitigation" is a term in the WorkSafe BC policy; the same term is used on the SSAP and was used by nurses when describing their morning work as well as when they spoke about their safety assessment and need to develop risk mitigation. The consistency of language from policy to the tools that nurses use demonstrate how the boss text is integrated into and directing nurses' work. As Sandy stated, the SSAP and check-in processes are in place to ensure that the health authority is following WorkSafe BC policy and for nurse's protection while they are out on visits. Nurses are aware of the requirement and complete the SSAP assessments on clients; however, as some shared, they may not check the SSAP each time, particularly when there is a client they have known, and will mark "low risk" on the itinerary

form unless there is a safety flag that pops up on the client record. Nurses shared that they do this because it saves time, and it is frustrating to continually copy information over to the form when they know the clients. Working around or avoiding the routine transcription of data does not meet the needs of the organization and creates a vulnerability for the nurses if information is missed.

Workarounds, as discussed in Chapter 5, are ways that nurses complete the work that needs to be done, in this case completing the safety checkboxes on the itinerary, in a way that may differ from how the documentation system or procedure has been established by the organization. As Jen shared, she often checks the safety risk score off knowing that the client is low risk, without checking the SSAP on PowerChart as outlined in their process. When people using the tools, in this case nurses, are not involved in the development of electronic health systems and documentation, they are more likely to utilize workarounds, as the system does not support their practice and needs (Ibrahim et al., 2020). Ibrahim et al. (2020) identified that up to 40% of nurses who are using electronic documentation systems in home care develop and/or use workarounds; some literature indicated this is as high as 67% (Ibrahim et al., 2020). Workarounds can negatively affect care delivery, as information may be lacking (Ibrahim et al., 2020), which may result in information not being communicated in a timely manner about potential safety risks. Standardization of the nurses' safety assessments and mitigation plans built into the electronic documentation system meets the health authority requirements set out by provincial policy (BC Health Standing Committee, 2011) while forcing workarounds for actual safety needs. As Kim and Bob shared, nurses ask the same questions to everyone about their home safety, pets, weapons, and such. These questions become standard, as they are asked to each client, and nurses then record these answers, which results in a low-risk rating that is

checked off on the itinerary each day. Standardization within nursing practices for the safety forms, including copying the risk scores from the electronic record to a form, has the potential to create errors while underestimating the complexity of risk in nurses' work and client experience. There are real consequences for the subordination of actual safety assessment and planning, and the transcription of values determined and used outside of their everyday setting also takes away time that nurses have to provide care. The itinerary form and SSAP represent a particularly narrow view of safety in nursing practice, one that renders invisible actual safety work of home care nurses.

Home care nurses are providing care in peoples' homes—sites that are not designed for ergonomic safety or the delivery of health care (Doran & Blais, 2013; Lang et al., 2008). On each visit, nurses assess and determine where to provide care, how to set up the supplies they need, and identify ways to maintain their safety and safety of the client (Demiris et al., 2019; Martinsen et al., 2018). While in the home, nurses are addressing emotional and social aspects of care while also ensuring they are physically safe to provide care (Lang et al., 2008). This entails addressing the physical safety features of the home environment as well as the stress and trauma that may be present in the family and caregiving dynamics and the networks of support (Lang et al., 2008). Nurses are also considering the needs for privacy as they provide client care (Al-Mazrooa, 2011). Sandberg et al. (2021) also noted the complex work of nurses and home support workers in identifying and mitigating risks when working with clients living with dementia, highlighting the dilemmas that emerge from changing situations and risks that change over time. Assessing, adapting, and addressing dynamics in a home environment are a part of the safety work and planning nurses do. This highly nuanced and complex safety work of home care nursing practice is not accounted for on the itinerary form, in the SSAP, WorkSafe BC (2008)

policy, or reporting requirements. Reporting only on safety from the worker policy lens misses critical work nurses do to routinely address safety in home care practice.

In addition to the home as a space to provide care, nurses also work out of their personal vehicles. With the implementation of the electronic documentation systems, nurses are asked to complete documentation of care on their visits. Several nurses reported this is not possible in many homes because they do not have time, but also it may not be safe. Nurses explained they most often complete their computer documentation in their vehicles, even though it is not ergonomically safe. They may have undergone physically demanding care with clients, in unique home environments, for instance changing a urinary catheter, attending to wound care or external stoma care for intestinal waste, or perhaps assessed the client for home rehabilitation and adjustments to adaptive equipment, which requires crouching to review beds, toilets, showers, or wheelchairs. It is following this assessment and care work that home care nurses sit squished in their vehicles, hot spotting the internet to complete their documentation; they may be parked in areas where it is not safe, and they may be compromising their physical health and safety.

The focus on worker safety provides for assistance to mitigate some safety concerns for nurses. As Jen and Ruth identified, nurses can ask for help from their managers if there are situations where they feel unsafe, and they have a formal check-in process to manage risk. Assessment and mitigation of risks is needed to support nurses to have a safer work environment, particularly because most of the nurses are providing care alone in homes and at locations throughout the community. Ensuring that assessment processes and documentation is meaningful and engaging for nurses is needed to assure that safety for nurses and home care staff is prioritized. However, recognition of the broad considerations of safety is also needed to ensure planning and dialogue is occurring for nurses on planning for safety in their work and for their

clients in their care. Nurses know and can inform leaders of changes that are essential in their daily practice to assist with enhancing the relevance of safety assessment and planning.

The SSAP and mitigation of risks for working alone safely are a narrow view into safety that needs to be broadened, recognizing the unique and dynamic environments and clients that nurses engage with in their home care work. Nurses balance their own safety client safety when they are providing care in their client's homes (Sandberg et al., 2021). The knowledge about safety that is privileged in home care practice is the focus on worker safety because of the legislated requirements for employers. This, however, misses the actual safety work in home care nursing practice and client safety in receiving care. Ruth shared that at each home visit she looks around and identifies where it is best to set up her equipment and how to make it comfortable for the client. The needs of clients and their families to ensure they are receiving safe care and are feeling safe in the care they are receiving in their homes is essential and needs to be included in safety planning. This work of assessing and individualizing care to ensure safety for the client and the nurse is not represented on the itinerary form. The form does capture that nurses have completed a visit and the risk safety level assigned by the SSAP assessment. These representations of work meet the health authority requirements to count visits and record that safety assessments were complete.

The Itinerary Form as Tool for Planning and Efficiency

In addition to the purpose of recording safety, the itinerary form is also used by nurses to plan their days, and, for the health authority, they are asked to record the number and type of visits they complete each day. The form requires nurses to complete standardized information each day about which clients will be seen, the types of visits completed, and their safety risk scores. The documented reality this creates stands in contrast to the highly individualized care

and complex decision making that nurses complete to determine and carry out their work each day. Bob and Kim spoke about what they take into consideration when they enter each client's home, ensuring they have consent, and confirming that it is okay for them to be there. Jen shared how she thinks about and approaches each client differently; for example, she stated, when clients are palliative, her "approach is really more mindful"—the task is not the focus. However, as nurses completed the itinerary form each day to plan their day, the end result is a list of clients seen. Nurses voiced the pressure they experience around efficiency, using their time and resources as best as they can. Inherent in this is the sense of restriction and shortage. Jen stated she feels a need to ration her time and is continually thinking about this in the organization of her day. While the itinerary form is completed through the chaotic process of morning work, nurses are influenced by the discourse of time restriction, task completion, and efficiency.

In the process of selecting, prioritizing, and setting times for client visits, nurses are taking into consideration what care is required, what resources are available, and which home care staff are available that day to provide care. In their prioritization and organization of their planning, they consider the priority rankings that were assigned to new clients, the tasks that need to be completed with clients, the length of the visits, and the type of visit that clients need. In this planning of their days and writing on the itinerary which clients will be seen, nurses are considering the best use of their time in order to be "efficient" and make the most of their day.

As I observed nurses' planning the order of the visits, timing, and routes; they used Google maps to plan the best route for efficiency of travel and time, and worked with each other to determine what clients need and how to juggle the day to fit the most in. Jen shared, "I definitely feel this pressure of myself racing the clock"; she spoke to "rationing" the need to plan her day and get out early so that she could be "a lot more efficient." The term "efficiency" that

nurses used in their description of organizing care for clients is reflected in the Island Health (2020b) *Service Plan* and the Ministry of Health mandate letter (British Columbia Ministry of Health, Office of the Minister, 2020). The Island Health *Service Plan* identified the health authority's commitment to provide "sustainable services through the effective use of human resources, digital and information technology, effective budgets … to improve organizational capacity and performance that enables service delivery" (Island Health, 2020b, p. 19). Consistent with this language, the mandate letter to the health authority from the BC Ministry of Health asserted the health authority needs to "improve productivity and efficiency while maintaining a strong focus on quality service" (British Columbia Ministry of Health, Office of the Minister, 2020, p. 13). The focus on increasing efficiency along with the constraints on time and resources reflect the values of the New Public Management ideology (Strandås et al., 2019). The notion of efficiency of time and resources comes from the larger influences of New Public Management regimes in health care, and home care is increasingly influenced by this regime to save costs and manage home care like a private business (Björnsdóttir, 2018; Jakobsen & Lind, 2022; Strandås et al., 2019). A challenge for nurses, as identified in this inquiry, is the misalignment with a focus on economy and efficiencies and nursing values (Strandås et al., 2019).

The focus on task completion has also been shown to break down care into discrete tasks that undermine the ability to engage in a holistic approach to working with people (Björnsdóttir, 2018; Jakobsen & Lind, 2022; Strandås et al., 2019). Several nurses in this inquiry identified the importance of taking time to build relationships, spending time with clients when questions about their palliative care emerged, rather than popping in and out to merely complete IV medication administration or other tasks. The focus on time and task reinforced by the itinerary form undermines the core relational, caring, family- and client-centred approaches in home care that

are necessary for quality of nursing care (Fjørtoft et al., 2021; Jakobsen & Lind, 2022; Strandås et al., 2019).

Scholars identified task focus and task shifting as concerns in home care programs (Denton et al., 2015; Kelly et al., 2021; Strandås et al, 2018). Task shifting is the identification of pieces of care, tasks, that can be transferred to an unregulated care provider to complete (Denton et al., 2015). In Ontario, task shifting was implemented to decrease costs and increase the number of people who can receive service (Denton et al., 2015). While researchers noted some potential benefits in the evaluation of task shifting, including reducing the number of people in and out of the home and the continuity of the care provided, they also expressed concerns about the quality of care, training, and supervision of the unregulated care providers (Denton et al., 2015). The process of delegation and task shifting requires serious consideration around the purpose, value, and impact for clients and the system (Ganann et al., 2019; Strandås et al., 2018). As Garland Baird (2018) established in her research on home care case management, the use of business process and integration model designed processes and texts that created redundant, time-consuming activities, moved case managers away from providing integrated care. The work of home care case managers was ruled by system-wide texts and procedures that reflected cost containment, efficiency, and a business process model that subordinated nurse knowledge in integrated care (Garland Baird, 2018).

When planning, nurses are balancing clients' preferences with the needs of the health authority in order to complete and meet their client allocation each day. As shown in Chapter 4, nurses give consideration to client's preferences for time of the visits, taking into account when clients have existing appointments or lunch schedules at assisted living facilities. However, Ray stated, if clients are scheduled for home visits, it is because they are homebound, and they should

be there when the nurse plans to come. Several nurses, in their observations and interviews, also alluded to this understanding of the expectation that clients will be available when the nurses are able to see them (Bob, Jen, Ray, Ruth, Sam).This approach prioritizes the requirements of the nurses to see their clients with the least amount of wasted time and lessens the consideration of the client's preference. To summarize, there is a tension between meeting the needs of the health authority, seeing the number of clients expected, and client's needs for timing and priority (Fjørtoft et al., 2021; Strandås et al., 2019).

Moving away from the set blocks of 30-minute visit times has allowed nurses in some offices the opportunity to have flexibility scheduling their client visits. However, nurses identified that if they scheduled too much time with a client, the nurse leader may ask them to decrease the visit time or may change the scheduled time in their calendar. While there appears to be flexibility and autonomy in setting schedules, leaders and managers do provide oversight on time allocated to client visits. The unwritten norms of how long visits should take influence the scheduling and planning work of nurses.

Nurses have the ability to schedule and prioritize their work, which is important as they have the knowledge about client needs. However, with the pressure of needing to see a greater number of clients as well as clients with more complex needs, nurses experience a shift to focusing on time with an intention to maximize the tasks being completed in the day, which impacts the holistic care provided to clients (Chan et al., 2013; Strandås et al., 2019). Relational work, which is critical to home care practice (Funk, 2013), is affected when time is restricted (Chan et al., 2013). Focusing on the time allotted results in nurses feeling like they are being timed by a stopwatch and the need to organize care for better use of their time (Jakobsen & Lind, 2022). The process of prioritizing can also lead to nurses experiencing moral distress, feeling

frustration, powerlessness, and guilt as they identify ethical challenges in which they are not fulfilling professional ethical roles while trying to balance the needs of the organization and their patients (Suhonen et al., 2018). Suhonen et al. (2018) also reported nurses' tendency to attend to the biomedical, clinical needs of clients, and then later the emotional, social, and relational needs that occur with prioritizing and rationing. Home care nurses navigate binary and contradictory requirements between meeting individual needs versus organizing work, following rules versus profession discretion, everyday life care versus medical follow-up trying to balance the reality that there is an increase in medical care and organizational work that means less time for relational and everyday care (Fjørtoft et al., 2020). The process of identifying who is seen and when is significant nursing work and has consequences for the clients and nurses.

While there are no documented expectations outlined for home care nurses' daily schedule, I found an observable pattern to the time nurses spend in the office planning in the morning and when they leave to go out on visits. As I observed, nurses arrive at the office at 8 a.m., the huddle is scheduled at 9 a.m., then the organization and collection of supplies occurs, followed by nurses leaving the office to travel to their clients' homes. As Jen stated, she feels pressure to leave the office and get started or the day will not go well, as she will feel behind. Nurses expressed concerns that they were spending too much time in the office and not enough time with clients (Jen, Bob, Ruth). While some of the tasks completed in the office are important nursing work, including coordination of care and communication, nurses also lose time to chasing down documentation and supplies and completing convoluted processes to delegate care, as highlighted in Chapter 4. Béland and Bergman (2000) and Chan et al. (2013) identified the burden of administrative work, such as documentation with duplication and fragmentation, could

lead to nurses having less time for patient care. On a typical day, half of home care nurses' time is spent organizing in preparation for client care and in the office for post-care work.

A trouble with the itinerary form is that the plan set in the morning may not reflect the work and time nurses spend on their visits in a changeable, complex world of home care needs, contexts, and people. Although managers and administrators may desire for the form to collect information about the visits and nurses' work, it is not accurately reflecting the decision making and adjustments nurses make throughout the day. Nurses are constantly managing their time and adapting their schedules as their day unfolds based on the client needs that emerge during their visits, needs that can never be disaggregated from highly individuated needs and contexts. As Bob identified, things "can go sideways" and the nurse may need to stay with a client longer than planned and recorded on the itinerary form in the morning. The ability for nurses to adapt and be responsive is important, as flexibility and the relational engagement contributes to client-centred care and well-being (Funk et al., 2022).

Home care leaders and managers must address the time that is available, support processes for planning and prioritizing the day, create spaces for nurses to engage in quality care, and reduce duplication of documentation and paperwork required. Nurse managers in home care face complex responsibility to meet organizational budget needs, economic constraints while also supporting relational and professional practice and support to staff (Jordal et al., 2022). Time for client care connects to the larger discussion on the number of clients nurses are working with and the allocation of clients to district nurses for their ongoing care and support. Sandy, a nurse leader, shared that it is challenging to determine what a caseload should be for nurses because client needs are so different. Identifying how many clients a nurse "should have" on their caseload is not clear within the health authority and is not an established norm. Nurses

reported that the work of district nurses in managing their caseloads is significant and too much to handle (Jen, Ruth, Bob) The Queen's Nursing Institute (n.d.) for community health nursing in the United Kingdom noted the challenge of establishing, evaluating, and ensuring safe caseloads for nurses and clients because, for home care nurses, "act like a 'sponge', absorbing additional workload in an environment without the physical limits of a defined number of beds" (para. 3). Establishing caseloads needs to include examining current demand for service as well as population health, demographics and a future orientation for planning (Queen's Nursing Institute, n.d.).

Nursing time is dependent on nurses being available as a human resource. In an era of nursing shortages there are constraints on the availability of nurses to the system and impacts on the time available for client care (CNA, 2021). Recent media reports have identified the shortage of home care nurses is dire and has resulted in more clients remaining in hospital because there are not enough nurses available to provide care in the community (Thompson, 2022). This nurse staffing crisis will create further limitations to how much home care can be provided.

The Itinerary as a Process to Objectify, Count, and Measure

One of the functions of the itinerary form is to record the number of visits completed each day by each nurse, which the health authority "sees" and reports as the work of nurses. The counts are anonymous numbers that strip the complexity from the work that nurses are doing and are intentionally created through the itinerary form to meet accountability and fiscal measurement requirements. The simplification of nurses' work into number of visits completed per day subverts nursing work into units of time that are not reflective of the knowledge and that go into the decisions and care nurses provide: "The actual caring for the patient has disappeared into drop-down boxes that send the message that the tasks that need to be documented are the

essence of nursing care and creates a checklist mentality" (de Ruiter & Demma, 2011, p. 27). Nursing work entered into electronic documentation systems becomes a database that does not reflect care and is for financial and risk management purposes (de Ruiter & Demma, 2011). It is a significant concern if decisions made about budgeting, workforce planning, structures of care systems are made using the limited data and view of nurses' work. The influence of the measurement and reporting needs of the health authority and Ministry of Health are clearly linked and present in the everyday work of nurses (see Figure 9 in Chapter 5). Researchers have noted the move to measure and ration home care nursing and the impact on shifting to a task-based approach with a narrow view of the practice of nursing in other countries around the world as well (Björnsdóttir, 2018; Martinsen et al., 2018; Strandås et al., 2019).

The time nurses spend coming to know the client, ensuring there is continuity in who is seeing the client, is not identified on the itinerary form. Continuity is highly valued by clients, and having continuity of relationship with care providers is an element of effective home care systems (Contandriopoulos et al., 2021). Hoe et al. (2022) further found providing continuity of care to be a key role for home care nurses in their work with clients living at home with dementia. Nurses consider continuity and what is helpful for clients when planning their client lists each day. As Figure 5 (found in Chapter 5) shows, the itinerary form records safety scores, the number of visits, and the type of visits; considerations of continuity in nursing care are not documented or reported to the nurse managers and health authority leaders who access the data for reports.

Electronic health systems in home care are coordinating the work of nurses. As shown in Chapter 5, the itinerary form is completed and entered in an electronic documentation system. Reports and data can be pulled from the system and have been used to inform planning for

staffing and budgets. Electronic health records (EHRs) are central in the daily work and use of the itinerary form. In addition to reporting the number of visits and the safety scores, nurses utilize multiple different EHRs to access information and document their care. Nurses spoke about the duplication of documentation, workarounds, and use of sticky notes or other paper notes to share information. While there are systems in place, this research highlights the opportunity to review the integration of systems and their use by nurses and other health care providers in home care (Dykes & Chu, 2021). Poor design of information technology impacts client care and results in workarounds; it is critical that there is a change to the culture that has previously excluded nurses from the design and decision-making processes regarding technology (Dykes & Chu, 2021). It is curious that nurses are transcribing the safety scores from one EHR onto the paper itinerary form for tracking safety purposes, and then clerical staff enter the number of visits per day on a different EHR system. Nurses spoke about the frustration of duplication and the time they waste searching out information. As shared earlier, Ruth identified the use of sticky notes can be problematic, however, it is what nurses are using to flag important information for colleagues. In addition to the challenges for nurses' work, the data created by the itinerary form and its subsequent entry into PARIS creates a limited set of data. Sandy shared how important it is for her, as a home care nursing leader, to contextualize the data from the visit count reports when she is speaking about nurses' work:

> It's so hard,… and people are not pigeon holes, they're not ticky boxes, you know? You go see a client and you could end up there for 3 hours because they're crashing palliative or their caregiver is crying and you can't leave them alone, you know, and that kind of thing. How do you measure something like that? It's impossible.

The work of explaining the data is crucial to developing an understanding of nurses' work; however, if managers who are pulling reports do not have the ability or experience in home care to contextualize the data, it creates a vulnerability that the work is simply reflected as the number of visits per day and the safety of care simplified into a risk score. Creating systems to accurately reflect the work and not adding more complexity to nurses' documentation could help with the gaps in what is currently being captured (Ibrahim et al., 2020). As Sandy noted, "Tangible data and measurement [capturing is] very hard in community services."

An additional challenge of accurately reflecting the work of nurses in home care is that it is often unseen work, completed in private homes, behind closed doors (Purkis, 2001). Caregiving work, often identified with women and body work, is undervalued (Purkis et al., 2008). Identifying and articulating home care nursing work is an important step in valuing the work. If the work is unseen and unknown, there is a limit to the ability to talk about and value it. Explaining what nurses do has been difficult; however, it is critical for nurses to be able to explain their work, as it informs workforce policy, including planning for adequate staffing and processes for ensuring their safety (Jackson et al., 2022). Extending the understanding of what nurses are doing beyond a count of visits is needed. Oldman (2022) proposed home care nurses need to articulate what they do and the impacts of it; they know what works and what does not, and they need to advocate for systemic change, as often nurses stay focused on client advocacy, moving nurses into the political realm. As nurse leaders Sandy and Jason identified, new programs are being developed by the health authority to provide care in the community, and these programs are duplicating existing home care programs. Part of their role, as nurse leaders in home care, is keeping on top of these developments so they can speak up for home care, advocate for existing programs, and determine how to best connect nurses with new initiatives.

There is an opportunity for home care, as an established program, to grow and meet the gaps and needs being identified by the health authority, rather than creating new, short-term funded programs that duplicate services.

What is Missed on the Itinerary

While the itinerary form captures some data about safety risk scores and home visits, much of the work nurses complete is not recorded. Nurses work to prepare the form, organize the care that will be provided, and attend to the needs of clients, but none of this is recorded on the simple itinerary form.

Balancing the Needs of the Organization and Clients

Nurses navigate multiple electronic and paper systems and layers of documentation to gather information, communicate with other care providers, and coordinate care. There is a juxtaposition of nurses needing to do this work to provide care, yet it pulls their time away from being with clients to provide care. In many examples, the documentation systems serve organizational objectives, not clients' needs. The reliance on multiple systems and expectations that nurses will navigate these also created a safety risk. As Sandy, a nurse leader, identified, the multiple documentation systems create vulnerabilities as the expectations of nurses to navigate and pull information as well as document in multiple places leaves room for omission and error. Nurses navigate systems to provide care to clients; this highly skilled and critical work is needed to ensure client care is coordinated, communicated, and provided.

Delegation of care to non-regulated health care providers requires additional layers of communication and care planning (British Columbia College of Nurses and Midwives, 2020). Nursing regulatory bodies have set many controls on practice that inform these processes, and the health authority has established processes and systems to facilitate these. Nurses need to

delegate care to ensure that clients have home supports that meet their needs. This process of delegation and establishing home support services can take hours, as it requires nurses to access multiple systems to complete delegation paperwork and set up a care plan for clients to receive home support systems.

Nurses also navigate between health and social systems for clients and are the ones to discuss payment for services. As Sandy, a nurse leader, noted, this is one of the only places in health care where nurses talk to clients about the costs for their supplies, services, and are required to complete financial assessments on clients as part of providing care. As home care is not fully funded by the provincial health system, clients are required to pay for certain supplies and services. Home care nurses and case managers are responsible for explaining, assessing, determining what supplies and services will be funded for clients and what they will need to pay for directly. These conversations impact the process of establishing relationships with clients. If nurses' work becomes focused on economic considerations rather than client needs, it can impede nurse–client relationships, trust, and a decrease the focus on wholeness and healing (Strandås et al., 2019). Sam shared she had avoided the financial assessment training because she does not feel comfortable with it and would rather a case manager complete the financial assessments if needed. She does not want to have conservations about the client's financial situation or fill out the forms required to establish financial needs and cut-offs.

Jason, a home care nurse leader, also identified funding issues and their impacts on the work he does. He shared that the wound care program is a significant budget item, and he is reviewing wound care products and care plans, evaluating care and costs, with the goal to reduce the expenditures. The managerial influences of budget constraints are influencing care. Nurses navigate this influence when determining which wound care supplies to use. They use their

nursing knowledge to identify products but also use the health authority product picker guidelines that direct nurses to good products and factors in least cost.

Managerial practices informing the development of assessments and allocation of services and supplies directly impact nurses' work. The cut-offs and categorizations of what is covered by the health authority reflects a value on short-term acute client needs. Funding is provided for wound care supplies for up to 2 weeks of care, and clients with longer term wound care needs are required to purchase their own supplies (BC Ministry of Health, 2019). There is provision for clients who receive income through the disability pension and there is funding for their products on an ongoing basis if nurses complete the required forms and requisitions. Additionally, supplies for home IV therapy are paid for and provided through the hospital IV program. Short-term, acute, biomedical services receive funding. Palliative care services for home support and all supply needs for clients are also paid for through provincial funding to the health authorities (BC Ministry of Health, 2019). These funding priorities reflect values and identify gaps for client needs, particularly for clients with ongoing chronic health conditions. Purkis (2001) and Duncan and Reutter (2006) identified the trend of treatment-oriented, short-term home care priorities over 20 years ago, yet these influences continue to shape the policies and practices of funding and care provision in home care today. Nurses navigate these influences and requirements every day in their work with clients as they determine eligibility for supplies and home support services that are set by provincial policies. The focus on cost containment coming from the economic discourse in health care has influenced home care through the use of rationing of services and standardization (Björnsdóttir, 2009; Ceci & Purkis, 2011).

Organizing Work

Home care nurses spend a significant amount of time organizing their work and client care. Between the intense morning work of organizing their day and the end of day work documents and coordinating care, nurses are left with a decreasing number of hours in the middle of the day to provide direct client care. The time to see clients and provide direct care is being squeezed out of the day. Bob shared that he could spend an entire day addressing emails, communicating with home support, sending and receiving communication from client care providers, and not actually seeing a client.

Organizing work is often invisible and taken for granted, but it is also the "glue in the health care system" (Allen, 2015, p. 3). In her research on nurses' organizing work in acute care settings, Allen (2015) identified, "Nurses have a central role in coordinating the ongoing organization of healthcare delivery and in order to undertake the function they must generate and keep in play a working knowledge of the evolving status of patient trajectories" (p. 33). Nurses have a role in leading multidisciplinary teams and building networks to provide care for patients. Organizing work calls on nurses to create a working knowledge of what is happening for clients, identify and articulate trajectories of care, pass the baton of care to others, and parse patients' needs (Allen, 2015). This practice is often discounted as not real work with clients; however, it is essential and needs to be included in understanding and allocating workloads (Allen, 2015). The organizing work and coordination of care should be factored in when considering how many clients nurses can work with in their geographic areas. Counting the client visits completed and recording these each day on the itinerary form does not reflect the work nurses are doing to coordinate care. Although the home care context differs from the acute care context, Allen's

(2015) reference to the work of nurses being invisible and often undervalued is relevant to this research.

Documentation systems, which influence the organizing work and care provided in home care, have become more complex as the requirement for transparency and accountability in healthcare has increased (Allen, 2015). In addition, information about patient care has become more detailed, fragmented, and increasingly difficult to find (Allen, 2015). In home care, nurses must navigate multiple documentation systems to locate and piece together information about clients and their care. Allen (2015) affirmed this, stating the work of pulling the client information together, parsing out what is needed by different care providers to ensure quality client care is the work of nurses. Allen (2015) further asserted that nurses oversee the client's trajectory and work to prevent fragmentation in their care. The work and time that nurses put into locating information and organizing and coordinating care needs to be recognized, as it is essential work for client care.

Coordination of client care is highly complex and an essential part of home care nursing practice (Björnsdóttir, 2018; Fjørtoft et al., 2021; Melby, 2018; Riekert, 2021). Care coordination is not identified or counted on the itinerary and is undervalued. The complex work of care coordination requires registered nursing competencies and skills (Nilsson et al., 2009). In Canada, discipline-specific competencies for home care nursing identify that care coordination is a key element of home care nursing practice (CHNC, 2010). In Chapter 4, nurses identified the time spent each day when they were in the office coordinating and communicating about clients and their care. Despite being essential, this work is not yet reflected on the itinerary count of daily work.

A more complete understanding about home care nursing work and how to best use the skills, knowledge, and time of nurses is needed. An understanding of home care nursing practice obscured by extra-local and highly standardized knowledge is lacking, and the various nursing workarounds only serve to further disorganize what can be known of nursing work, safety, and time management. Björnsdóttir (2018) identified home care nursing work as relational, ethical, and collective, whereby nurses create a net of support around clients to ensure they have the services they need. This work is complex and involves knowledge, creativity, attentiveness, and flexibility by nurses (Björnsdóttir, 2018; Fjørtoft et al., 2021; Riekert, 2021). Ensuring that nurses are engaged in the communication, documentation, coordination work, and not the work of duplication and layers of reporting for the system is essential. Sandy, a nurse leader, noted some nurses have left home care because there was too much paperwork and not enough time with clients. This example highlights concerns with the balance of paperwork and client time and also highlights an issue of understanding what nurses' work in home care is. The itinerary itself is an example of nurses creating a record to be keyed into a computer system of information that already exists in another computer systems. In a time when there is a nursing shortage and a growing need for home care nursing, health care administrators must develop a better understanding of the work of nurses and examine how best engage nurses in client care.

The Cost of Home Care

Home care is not a part of the Canada Health Act (1985), which results in a mix of what care is covered by the health authority and what is paid for by the client (Health Canada, 2016; Johnson et al., 2018). As previously noted, Sam has not taken the training to complete financial assessments with clients because she finds it uncomfortable. Sandy, a home care nurse leader, highlighted that home care is one of the only programs in which nurses must talk to clients about

how much care will cost and the expenses of staying at home. BC Ministry of Health (2019) policy identifies which supplies will be covered and for how long; for example wound care supplies are paid for 2 weeks post-discharge, after which time the client must purchase the supplies themselves (BC Ministry of Health, 2019). On their visits with clients, nurses discuss the costs of equipment, hiring additional home support help, medications, and supplies. The discussion with some clients leads nurses to ask if they can afford to remain at home; as additional expenses grow, clients may need care in an institutional setting, where supplies and care are paid for through the health authority. The "economics of caring is a growing issue" (Macdonald et al., 2013, p. 139), whereby the responsibilities for care and the personal costs are shifting to client homes. A recent policy analysis in England similarity identified the challenges of payment schemes in home care that have created a commodification of care leading to services that are lacking budget, and the shift to community care has not been incentivized (Bramwell et al., 2023). Bramwell et al. (2023) noted an additional challenge in how services are funded is the need to show outcomes are met given the lack of good data about home care activities.

Conclusion

In this chapter, I have drawn on the data, analyzed textually, to address the problematic and the conundrum of knowing how and what home care nurses are doing and how that work is organized. Home care nurses are increasingly providing advanced care to clients in the home, coordinating, delegating, and prioritizing client care (Björnsdóttir, 2018; Melby, 2018; Nilsson et al., 2009; Strandås et al., 2019). Home care nursing, as described by the nurses in this inquiry, is complex and coordinated by ruling relations connected to safety, standardization, measurement, and efficiency. Globally, the shift to an economic discourse in health care focused on efficiency

and cost containment have led to rationing of home care services, rationing of care, standardization of processes, a focus on task, measurement and a loss of holistic relational-based care (Björnsdóttir, 2009, 2018; Strandås et al., 2019). This work is informed by a market-based system influenced by capitalism. Examining nurses' use of their daily itinerary form revealed direct links to information systems, provincial policies for safety, and reporting influencing the daily work of nurses. These local and provincial policies have informed the development of the itinerary tool, are used in assessments, safety planning, and the language used in the policies, and are present in documents and day-to-day communication with nurses (see Figure 9 in Chapter 5). Nurses are at the interface with their clients and the health care system, attempting to provide care that is ethical and safe while navigating and being impacted by these larger global influences. While nurses have the knowledge, skills, and the capacity to inform change and address issues, their work and knowledge is being distilled and subverted by standardized reporting requirements. Home care nurses impact the health of clients they work with at the individual and family levels and have the potential to impact care systems when they are involved in directing and designing care delivery (Ganann et al., 2019).

Chapter Seven: Recommendations – Opportunities for Change

Home care nursing is complex socially organized work. Through this inquiry I described the day-to-day work of nurses and explicated how the home care nursing itinerary form is a text that coordinates the work nurses accomplish across sites. The ethnographic descriptions of the setting and activities of home care nurses highlighted the text and talk of home care nurses' work. Analysis of the coordinating texts, WorkSafe BC (2008) policy, and BC Home Health Standing Committee (2011) minimum reporting requirements and the codified language identified how New Public Management discourse (Strandås et al., 2019) is imported across settings. This thesis made visible the ruling relations of safety, measurement, efficiency, accountability, and standardization and aspects of New Public Management regimes and neoliberalism. The language used in the texts and by nurses in their work identify how the discourse is influencing and organizing nurses' work. Language is culture and the culture of home care nursing is troublesome. Changes are needed to address that troublesome culture.

Learning about the ruling relations of home care nursing practices alone does not change those practices and power relations. As an approach to inquiry, IE makes visible the complex relations that are coordinating work (D. E. Smith, 1990, 2005). Identifying these influences allows for critique of the power in ruling relations, which is a key outcome of the inquiry (D. E/ Smith, 1990, 2005). Additionally, IE intends to create change from below (D. E. Smith & Griffith, 2022), whereby the coordination and influences of power opportunities to create change are exposed. In this inquiry, identifying the work and ruling relations of home care nursing work is one important step in articulating the practices of power and coordination in home care. As such, I put forward recommendations bearing in mind the power relations and the desire of those in places of power to address the challenges of home care nursing. These challenges have never

been more present than during the COVID-19 pandemic; issues in long-term care were raised, but despite this home care solutions minimally entered the political discourse (CNA, 2020; Palmer et al., 2022). Disparities in access to home care and the dichotomous gap between user pay and publicly funded services grew during the COVID-19 pandemic (Palmer et al., 2022). In this chapter, I discuss recommendations for change in nursing practice, information systems, policy, research, and nursing education as well as the limitations of this research.

Opportunities for Change in Nursing Practice

Learning about the objectification of nurses' work and the subordination of knowledge does not result in a change to these conditions. However, uncovering and making visible the social organization of home care highlights places in which actions can potentially influence change and contribute to moving forward an environment for home care nursing that supports something different.

The original question that led to this inquiry focused on the visibility of home care nurses in the media and literature. Reading about new paramedicine initiatives to support community palliative care programs and seeing that there was no mention of home care nursing led me to question the overlap and support that the programs offered. The work of home care not being seen in literature and the media has resulted in a vulnerability that the work is not recognized and valued. Increasing presence can happen with nurses, within the data collection systems, formal reporting, and through research. Home care nurses need to talk about their work and the effects it has on the health of their clients and community. As Oldman (2022) and Purkis (2001) identified, home care nursing work is political and nurses must engage in processes to make their work visible. This is not about party politics necessarily, but about the political processes of identifying and articulating nursing practice (Oldman, 2022). Talking about their day-to-day

work, home care nurses can describe the essential roles they have in assessments, decision making, communicating and managing care, making contact and building relationships with clients. Talking about the results of their work nurses can advocate for change to increase the understanding of home care and their impacts.

Advocacy has been a long standing part of nursing practice (Chiu, 2021). Advocacy for social justice issues such as access to adequate care in home care and resources to meet the needs of clients is nursing work (Abbasinia et al., 2020; Chiu, 2021; Scott & Scott, 2021). However, it is challenging for nurses to take on advocacy roles. These challenges include time, a lack of education in advocacy and policy cycles, concern about retaliation if issues are raised, workplace cultures in which nurses feel their input is not values or acted on, and a sense of powerlessness (Bartmess et al., 2022; Chiu, 2021; Scott & Scott, 2021). In order for nurses to speak up and contribute to changes in home care, there needs to be improved communication and culture change for nurses to feel their input matters and is acted on (Bartmess et al., 2022). Staff meetings are a concrete opportunity for nurses to learn about changes within the health authority and practice and to contribute their ideas to change and address issues in their practice settings. During this inquiry, several nurses identified that they were no longer having regular staff meetings with their nursing team. They also spoke about how morning huddles were less meaningful now that they were being held via phone rather than in person. Professional practice models that include shared governance, for example nursing practice councils, have shown beneficial outcomes for nurses and client outcomes (Hamilton et al., 2023). Creating opportunities for nurses to meet and talk is an essential first step for home care teams to create spaces and time for nurses' voices to be heard.

Nursing education on policy and advocacy moving beyond individual client advocacy and the role of nurses as advocates contributing to policy change needs to be seen as nursing work (Chiu, 2021). Nurses sharing their stories about practice and the unique roles they have in home care presents an opportunity to build understanding and spread knowledge about home care nursing practice. Nurses can also raise issues through professional associations such as the CHNC, using methods such as policy briefs and campaigns (Chiu, 2021). With changes to nursing colleges and professional associations (Duncan et al., 2015), nurses who are keen to take on a voice and role to influence change have to find associations who have capacity and a mandate to support policy and advocacy work. National organizations such as the CHNC and the Canadian Home Care Association could be places for nurses to find support to speak up about opportunities for change and improvement. However, increasing the presence and understanding of home care work cannot rest solely with the nurses who are engaging in direct client care day to day.

At a health authority level, decision makers who set budgets and annual priorities need to learn about home care and the contributions to health that nurses make. At provincial and national levels, home care nurses' work must be represented to ensure that there is adequate funding and policy support for home care programs. Ensuring that home care nurse leaders are included in decision-making meetings and at policy tables could help to increase the understanding and presence of home care. Nursing representation is needed to address the broader conceptualizations of safety, to contribute to the development and implementation of technology, and to ensure the understanding of home care nursing work is comprehensive. With increasing demands for home care in Canada (Canadian Healthcare Association, 2009; Canadian Home Care Association et al., 2016; CNA, 2013; Chappell, 2011; Garland Baird & Fraser, 2018;

C. Johnson et al., 2017; S. Johnson et al., 2018) there are growing requirements for funding and supports for home care nursing.

Through the analysis of the itinerary form and its use in nursing work ruling relations connected to efficiency and measurement were identified. Nurses spoke about the need to ration time to complete their visits and the visit per day numbers were counted and reflected on the itinerary. A part of the conversation about efficiency highlighted by a nurse leader was the move to increase clinic-based care and decrease the number of home visits that nurses do. Tara, a nurse leader, shared that it is a better use of time to have the clients come into clinics rather than travel out to all of them. The assumption that clinics are a more efficient use of time and a better model requires further investigation. Several nurses spoke to the value of home visits, seeing clients where they live and understanding their health differently because of what they see in the home. The definition of what counts as a visit for home care needs to be revisited to reflect the work and time of home care nurses. Ruth shared an example of a client who said they were managing their medications well; however, when she went out to their home, medications were piled on the bathroom counter, revealing a number of issues the client was having in managing their medications. Although the number of clients seen in a day may increase with clinic visits, because travel time for nurses is eliminated, this may not result in better care outcomes for clients. The burden of time and travel is shifted to the client and their family and nurses lose contextual information gained when working in a home. Fjørtoft et al. (2021) found in their research with home care nurses that working in clients' homes led to more holistic care, as it enabled nurses to assess the client as a whole person rather than just a diagnosis. As Pat shared, teaching a client with a new colostomy in the bathroom at the clinic is not as beneficial as being in their own home, in their bathroom, where they will be setting up their supplies to take care of

their appliance every day. If efficiency, a focus on increasing the number of clients per day, drives decision making about location of visits, the potential loss of home visits could have significant impacts that need to be further understood. The importance of visiting clients in their homes need to be articulated and shared.

Home care nursing work is represented by data collected from a checkbox on the itinerary form. There are limitations in the representation of what home care is with the current use of data from information systems. A count of visits per day does not provide a full view of the care and work that home care nurses do. As Ginger stated, this type of documentation does not reflect home care nursing work:

> It [is] frustrating that we were getting pushed to document in IView [a computer form in EHR], but in community a lot of our documentation is contextual in nature there needs to be context around it, we are in people's homes there's so many other influencing factors other than just a ticky box, or something you pick off a menu.

The itinerary form and the information generated from it should not be used to explain home care nursing work or to justify new positions. The complex work of case coordination and the time needed to organize and document work needs to be represented in home care nursing data collection tools. Creating a way to represent nurses' work more accurately could benefit nurses in being able to show their time and work, the leaders in being able to more clearly articulate the need for nurses, and the organization to be more accurate in their description of nurses' work and access more rigorous data for their decision making. Given that there are already multiple EHRs and systems for reporting, the best way forward would be to align reporting with one of the existing systems. As Ibrahim et al. (2020) identified, involving nurses (i.e., the users) in the design of a system is necessary to create a usable system that fits with the complexity of their

practice and prevents workarounds. While there is a need to develop better, streamlined ways to represent nurses' work, resisting the pressure to be counting and measuring all work is also needed, why and how work is represented needs to be asked. However, given the current requirements by the BC Home Health Standing Committee (2011) and federal reporting systems, such as the Resident Assessment Instrument, there needs to be better ways to represent home care nursing work within the system requirements for reporting. Making the unseen work of nurses seen and recognized in reporting systems is critical to ensure that decisions about programs, funding, and services for clients are based on accurate information. Information Technology systems staff could work with nurse leaders to identify reports that would be more representative of nursing work; reports could be generated from the existing EHR data sets. While larger system changes could be made to access already existing information, the itinerary form as a tool could be updated to include a column about coordination of care and time spent with clients and on coordination. Additionally, home care nurses and their managers could inform changes to the itinerary form that would be meaningful for representing their work and reduce duplication.

Within the home care team there is a dedicated Community Resource Team (CRT) that is in place to provide education and support to home care staff. Nurses identified that they were not sure who the team members are and it was unclear how to access support as the team was working remotely. However, nurses and nurse managers identified that the CRT developed the itinerary tool and is responsible for providing education support to home care nurses. In contrast to the CRT, nurses identified that the End-of-Life Team education and support teams are accessible, supportive, and present. The model of support used by the End-of-Life Team should be available for the home care nurses in their daily work with clients who are not on the

palliative care program. Home care nurses are working with clients who are increasingly ill, unstable, requiring more specialized medical procedures, independently assessing and determining care (Fjørtoft et al., 2021); in order to continue this work, home care nurses need increased access to education and clinical supports.

Engaging nurses' voices and experiences in decision making at multiple levels is crucial to creating positive changes. When nurses are involved in governance and decision making, organizations produce better outcomes for nurses and clients (Bartmess et al., 2022; Hamilton et al., 2023). At local levels, nurses can contribute to discussions about workload and geographic boundaries to provide the context and knowledge of the day-to-day work to inform good decisions. This can happen through staff meetings and regular opportunities for nurses to meet and problem solve and provide input into changes in practice. At a macro level, nursing input is needed in decision making about information systems, resource allocation, systems flow, and structures. The knowledge nurses have about their work and clients is required to address the complex issues they face. Nurses in this inquiry shared that they wanted to make things better and to learn from the research what was impacting their work. Jen shared that she feels the pressures and knows there are ways to make it better.

Nurse-led models of home care are effective (Ganann et al., 2019). Following up on previous recommendations (CNA, 2012) to implement these types of model in Canada could offer an innovative, effective model for home care. Policy commitment to this change is required.

This IE research was oriented from the standpoint of home care nurses. The work of home care nurses is coordinated by extra-local discourses. Nurses who are engaged in day-to-day home care nursing practice may not have the view to see the ruling relations that are coordinating

their work. As shown in the Small Nurse Hero diagram (see Figure 9 in Chapter 5), the coordinating policies based on values of measurement, efficiency, and risk management that are influenced by neoliberal ideologies are critical to identify, speak about, and challenge. Further IE research will help to show the extra-local coordination, identify knowledge that is being authorized, and surface opportunities for systemic change. A previous IE in home care identified the work of nurses in wound care, translating what is happening with clients wounds into predefined forms and measures to create categories and scores that abstracts people's circumstances from wound care and results in practices focused on saving money and time (Waters, 2016). Using IE, Øydgard (2017) identified three discourses contributing to informal caring in home care that impact caregivers, moral and family obligation, shared care, and tasks specificity. Identifying the extra-local coordinating influences and authoritative knowledges used reveals the tensions and places where change is needed.

Information Systems

Threaded throughout the conversations with nurses to the analysis and results is the impacts of electronic documentation systems on nurses' work. Nurses forage through multiple information systems and paper documentation to synthesize information about their clients and share communications with other care providers. The home care nurses' morning circus and their afternoon documentation and communication detracts time from direct client care. All electronic documentation systems, including PowerChart, PARIS, and Procura, take time for nurses to navigate through and may not assist them with the work they are trying to accomplish. As noted earlier, nurses are using sticky notes and paper charts to meet their needs to communicate with each other even though there are multiple EHRs in use. Electronic documentation systems are also influencing and guiding the work of nurses, as was found previously in studies about

electronic documentation systems in acute care settings (Campbell & Rankin, 2017). At a local level, nurses have suggestions for changing the documentation processes to strengthen the effectiveness of management, the organization, and service to people. Holding meetings with the Information Technology Team and the CRT (education support) for nurses to share their experiences, the benefits and challenges, and solutions for their use of the EHR systems could help to include nurses' voices and produce better products and processes. Ongoing opportunities for collaboration on systems change and input could be helpful. At a macro level, a review of the EHRs with a look to improve integration is needed. How can the systems connect so that nurses no longer need to open three different applications to find information about a client.

The itinerary is an example of paper documentation that nurses complete daily, which is a composite of information available on the electronic systems. Nurses use the document to plan their day; however, what is required for reporting is information recorded on existing electronic systems. Why are nurses being asked to collate and copy this information daily and use clerical time to enter information already in systems? Nurses could be involved in designing a process and systems to address the need for safety monitoring and check-ins. Ruth shared that she has insights about the safety processes and how to improve them. When the people who use the electronic documentation systems are involved in the development, updates, or enhancements of the systems, fewer workarounds are needed, resulting in a better use of the systems and more comprehensive data (Ibrahim et al., 2020). Currently, nurses are asked to report issues with the documentation systems; however, this is not a proactive approach that allows for suggestions on improvements and usability for those using the systems daily. Within the health authority, the information management teams should include nurses who are using the systems and providing care to help inform the use and changes to the system. At provincial and national levels, nurses

must be included in discussions about electronic documentation systems to represent their perspective and to make the systems more functional.

The Praxis Safety and Accountability Audit process developed by Ellen Pence offers an approach to examining safety (Sadusky et al., 2010) that could be helpful for home care use. Developed and used with women experiencing violence, the tool could be used to examine how home care is standardized and is coordinating nurses and staff actions to produce outcomes and interventions that impact safety—it is a tool to create change (Sadusky et al., 2010). The audit process uses interviews, observations, and text analysis to ask how safety is being addressed from a specific standpoint to discover gaps and build on strengths (Sadusky et al., 2010). The safety audit process would offer important learnings and opportunities for change to improve safety in home care.

This inquiry identified the use of the itinerary tool as having a different purpose for the nurses than for leaders. This is due to the use of information for documentation and communication versus the use of information for data collection and reporting. Clarity about how information will be used is needed to build a collective understanding about information gathering processes and purposes. Integration of electronic systems to alleviate duplication and time needed to search could decrease the complicated layers of information collection and sharing.

Policy

The policies of WorkSafe BC (2008) guide home care nurses' work in assessing safety and mitigating risks in their practice. The focus on working alone and worker safety limits the assessments and actions taken on safety. Creating an opportunity for home care nurses and their managers to discuss what safety is in their practice and how to ensure safe practice for

themselves, their clients, and their care is imperative. Safety policy needs to be better defined, moving beyond the focus on risk mitigation to understand the diverse challenges in safety, including the navigation of working in clients' personal homes, in spaces and places that present safety issues, and the psychological safety of nurses engaging in client care that is relational and offers a different connection because of the immersion in clients' homes and personal settings. Nurses require opportunities to debrief with colleagues and managers to respond to the variability and autonomy that they face in providing care in home settings. Training and education for nurses about the variability in settings and needs of clients as well as supporting client autonomy (Heggestad et al., 2021) and care would help prepare nurses for the diversity of decision making and ethical challenges they may face. Caregiver and client safety also need attention, as Macdonald et al. (2013) noted safety for caregivers and clients receiving home care has broad considerations, including the sense of being left on their own to manage their health, communication difficulties, having strangers come into their homes—often many different people coming and going, meeting increasing and changing care needs and responsibilities, out-of-pocket expenses, and declining health of caregivers. Further research on safety in the home care context is required to identify safety issues, develop strategies to address safety concerns, find ways to enhance safety for clients and caregivers, and provide education (Lang et al., 2006).

Home care programs in Canada are not included in the Canada Health Act (1985), which has resulted in a variation in programs and services across the country (Canadian Healthcare Association, 2009; Johnson et al., 2017). Given the increasing need for (CIHI, 2017) and the desire of Canadians to have home care services available (CNA, 2014), adequate funding and standards for home care across Canada are needed. Based on the focus on safety, time and resource management, and work that nurses do in preparing their itineraries from a place of

knowing clients, relational practice, and ethical requirements, home care nurses need a greater emphasis placed on funding for nurses' education, support, and training. With the increasing focus on budgets and fiscal responsibility following business practices (Björnsdóttir, 2009), adequate budgets for home care are needed. Palliative care programs and short-term acute needs are supported (BC Ministry of Health, 2019); however, the longer term needs of people living with chronic illness continue to be limited in policy and funding priorities. Recognition of the work of nurses that includes the relational and ethical components of practice could help to inform better policy and decisions about how to fund and evaluate nursing practice. There needs to be an identification of the outcomes of home care nursing work rather than narrowly focussing on the volume of clients seen.

The COVID-19 pandemic raised the profile of the needs of people living in long-term care; alongside this conversation, a dialogue about home care is needed (CNA, 2020) to support and provide care to people who require medical care and supports and want to continue to live at home. Researchers have identified policy recommendations addressing systemic changes that are needed in Canadian home care systems; however, over the decades there has been no action by the federal government on these changes (Johnson et al., 2017). Recommendations including the need for better funding of home care (Canadian Health Coalition, 2018), the development of a national home care policy (Sharkey et al., 2003), and identifying a national suite of home care services (Romanow, 2002) and national home care standards (Canadian Home Care Association et al., 2016) continue to be relevant today. New investments in home care, akin to the investments in palliative care programs, are required to ensure that nurses can provide the care clients need in community settings. Actions on the recommendations are needed to ensure the sustainability of home care and to address issues faced by nurses and clients with a system

influenced by an economic discourse of restraint, saving acute care dollars, and efficiency to provide more client care with less time and money. Policy work to ensure home care remains publicly funded and accessible is critical as the commercial enterprises of private services infiltrate into home care systems. There is an opportunity currently to address the needs of home care in Canada as Canada's premiers and the prime minister come together to address health care reform and planning and discuss a new health agreement (Hunter et al., 2023). This is a critical time to address the long-standing policy recommendations for home care as well as the need for funding and home care policy.

Research

Research to build knowledge about home care and home care nursing is needed. Funding to support research in home care is required to support knowledge development. Nurses in this study shared that they were keen to be heard and to have their knowledge be a part of a research process. Nurse leaders identified they need evidence on caseloads in home care nursing, what is safe, and how to plan for the number of clients nurses can safely provide care to. Research that increases the understanding of the work of home care nurses and the impacts of their work is essential. Contandriopoulos et al. (2021) found mismatches between what is being evaluated in home care research and what the intervention was. Home care is far more than a way to save costs from acute services (Ceci & Purkis, 2011); therefore, research on home care needs to evaluate more than cost savings. Evaluating and identifying the impacts of home care needs to continue with better measures and questions that align with the care being provided, highlighting how home care impacts quality of life for clients, their families, and caregivers.

Continued research on caregivers' and clients' outcomes is critical, as the continued reliance on caregivers to provide home care work is increasing amounts of caregiver distress

(CIHI, 2020). Home care has existed for hundreds of years in Canada (Gibbon, 1947; Grypma et al., 2012), yet there is limited presence in the literature and media about this work and its significant contributions to the health of people and communities. Knowledge about systems and what helps to make home care systems work well is also needed. The Tackling the Home Care Challenge research project funded by Canadian Institute for Health Research is an example of systems-level research aimed to improve home care in Canada (Stajduhar & Contandriopoulos, 2018) and shows promise in influencing change. There are many opportunities for ongoing research and sharing of knowledge back to practice.

This inquiry has impacted my understanding and approach to research and home care. As a nurse educator, I have integrated these lessons learned about home care nursing practice into my teaching with students. I teach community health nursing courses and have been able to speak to the complexity of home care nursing work, the role of electronic documentation, and safety with students. I have a new understanding about the coordination and influences of work that contributes to my perspectives about health care systems and nursing work. On account of this learning, I have been more intentional when encouraging students to examine ways to raise their voices and influence systemic change. Additionally, this work has provided me with increased evidence and passion to lead curriculum change, emphasizing the roles nurses have in community health settings and the need for this to be embedded in undergraduate theory and practice learning. I intend to publish the findings of this dissertation with my committee to contribute to the body of knowledge in the literature about home care nursing, focusing on the work of home care nurses, the discourses organizing their work, and the need for changes in policy, practice, and research. I will also present these findings at upcoming conferences with the intent to inform, based on this work, and dialogue about opportunities for change in home care.

Limitations of this Inquiry

This inquiry provided me an opportunity to talk about the work of home care nurses and show the coordinating influences on their everyday work. Nurses participating in this work were keen to talk about their work and welcomed me to observe their practice. This research offered nurses the opportunity to reflect upon, discuss, and investigate their work—and to be heard. Given the increasing demands and complexity in home care nursing, continued research and learning is needed. Using IE provided a view into the social organization of nurses' work and identified opportunities for change. While there is much to be learned from this work, I also found limitations to the data. Due to COVID-19 restrictions during data collection, I was unable to observe nurses' work in client homes and as they made their way around the community. The nurses described their home visits in rich detail; however, I was not able to observe the settings and nursing work myself. Engagement with clients could offer additional information about nurses' work and insight into the power of clients and caregivers to speak about their experiences and influence change. Diverse participants took part in this study; however, few were district nurses with more than 5 years of experience that contributed to the data collection. More district nursing voices would add a perspective to this work that could offer greater insights. With my analytic focus on the itinerary, I identified ruling relations in home care nursing work; however, there were many other tensions and rubs present in the nurses' work that were not explored in this study. There is much to learn about workload, support, and education for home care nurses, mentorship for new graduate nurses entering home care, the influences of electronic documentation, and understanding the care being provided by nurses and the impacts on client health and health outcomes. Finally, this research focused on the standpoint of home care nurses;

several other perspectives could be explored to further learn about home care, including caregivers, clients, and nurse leaders.

Conclusion

Home care nursing is a critical component of health care systems in Canada, yet little is known about the work of home care nurses and the factors influencing their work. Home care nursing has become invisible and the complexity of the work of nurses unclear and underrepresented in health systems; the erosion of publicly funded home care services has created troubles. The particular managerial emphasis on accountability, efficiency, and measurement has reshaped how home care happens and is disorganized. Change is needed and can happen to improve home care.

In this study, I used IE in one health authority in BC to learn about the social organization of home care nursing. Through the process of institutional ethnographic analysis, I identified discursive influences such as efficiency, safety, and accountability that are organizing nurses' work. Systems created to count, standardize, simplify, and subvert complex nursing decisions and knowledge are used daily in home care practice. The itinerary is a tool and a process that introduces these systems and efficiency values, and paradoxically creates more work for nurses to pull and enter data that are not about client care but rather institutional needs. Relational and ethical work of nurses in coordinating and providing direct care to clients is increasingly squeezed out of the working day while documentation, duplication to communicate through multiple records and methods, including phone, fax, and computers, are increasing. There are opportunities to change the troubles described in detail in Chapters 4 and 5, through building better understanding of what is going on, making the invisible aspects of the itinerary and safety measures visible, talking about the work of actual home care and outcomes, researching

alternatives, and educating nurses about home care and home care nursing work. Changes to funding to ensure the home care system is adequately supported, national standards for home care service, and policies to ensure nursing education, support and training are in place are needed to make significant changes in home care nursing work. With the increasing calls for expanded home care in Canada, it is imperative to turn the gaze of policy and research attention to home care nursing. Nurses' knowledge and their voices are needed to create impactful changes in home care.

References

Abbasinia, M., Ahmadi, F., & Kazemnejad, A. (2020). Patient advocacy in nursing: A concept analysis. *Nursing Ethics, 27*(1), 141–151. https://dx.doi.org/10.1177/0969733019832950

Adams, S., Carryer, J., & Wilkinson, J. (2015). Institutional ethnography: An emerging approach for health and nursing research. *Nursing Praxis in New Zealand, 31*(1), 18–26. https://dx.doi.org/10.36951/NgPxNZ.2015.002

Allen, D. (2015). *The invisible work of nurses: Hospitals, organisation and healthcare*. Routledge.

Al-Mazrooa, A. A. (2011). Evolving nurses into home health care practice. *Home Health Care Management & Practice, 23*(2), 118–124. https://dx.doi.org/10.1177/1084822310384919

Armstrong-Stassen, M., & Cameron, S. J. (2005). Concerns, satisfaction, and retention of Canadian community health nurses. *Journal of Community Health Nursing, 22*(4), 181–194. https://dx.doi.org/10.1207/s15327655jchn2204_1

Aronson, L. (2019). *Elderhood: Redefining aging, transforming medicine, reimagining life*. Bloomsbury.

Austin, W. J. (2011). The incommensurability of nursing as a practice and the customer service model: An evolutionary threat to the discipline. *Nursing Philosophy, 12*, 158–166. https://dx.doi.org/10.1111/j.1466-769X.2011.00492.x

Balcom, S., Doucet, S., & Dubé, A. (2021). Observation and institutional ethnography: Helping us to see better. *Qualitative Health Research, 31*(8), 1534–1541. https://dx.doi.org/10.1177/10497323211015966

Bartmess, M., Myers, C., & Thomas, S. (2022). 'It would be nice to think we could have a voice': Exploring RN involvement in hospital staffing policymaking. *American Journal of Nursing, 122*, 22–31. https://doi.org/10.1097/01.NAJ.0000884564.75005.a9

BC Home Health Standing Committee. (2011). *Home and community care minimum reporting requirements visit definition*.

Béland, F., & Bergman, H. (2000). Home care, continuing care and Medicare: A Canadian model or innovative models for Canadians? *HealthcarePapers, 1*(4), 38–45. https://dx.doi.org/10.12927/hcpap..17349

Bisaillon, L. (2012). An analytic glossary to social inquiry using institutional and political activist ethnography. *International Journal of Qualitative Methods, 11*(5), 607–627. https://dx.doi.org/10.1177/160940691201100506

Bisaillon, L., & Rankin, J. M. (2013). Navigating the politics of fieldwork using institutional ethnography: Strategies for practice. *Forum Qualitative Social Research, 14*(1), Article 14. https://dx.doi.org/10.17169/fqs-14.1.1829

Björnsdóttir, K. (2009). The ethics and politics of home care. *International Journal of Nursing Studies, 46*(5), 732–739. https://dx.doi.org/10.1016/j.ijnurstu.2008.10.014

Björnsdóttir, K. (2018). 'I try to make a net around each patient': Home care nursing as relational practice. *Scandinavian Journal of Caring Sciences, 32*(1), 177–185. https://dx.doi.org/10.1111/scs.12443

Björnsdóttir, K., Ceci, C., & Purkis, M. E. (2015). The 'right' place to care for older people: Home or institution? *Nursing Inquiry, 22*(1), 64–73. https://dx.doi.org/10.1111/nin.12041

Blackburn, S. (Ed.). (2016). *Oxford dictionary of philosophy* (3rd ed.). Oxford University Press.

Bramwell, D., Checkland, K., Shields, J., & Allen, P. (2023). *Community nursing services in England: An historical policy analysis*. Palgrave Macmillan. https://dx.doi.org/10.1007/978-3-031-17084-3

British Columbia College of Nurses and Midwives. (2020, November). *Practice standard for nurse practitioners and registered nurses: Delegating tasks to unregulated care providers*. https://www.bccnm.ca/RN/PracticeStandards/Lists/GeneralResources/RN_PS_delegating.pdf

British Columbia Ministry of Health. (2019). *Home and community care policy manual.* https://www2.gov.bc.ca/assets/gov/health-safety/home-community-care/accountability/hcc-policy-manual/6_hcc_policy_manual_chapter_6.pdf

British Columbia Ministry of Health. (2021). *Home and community care data set*. https://www.popdata.bc.ca/data/health/hcc

British Columbia Ministry of Health, Office of the Minister. (2020). *Minister of health mandate letter*. https://news.gov.bc.ca/files/HLTH-Dix-mandate.pdf

Campbell, M. L. (1998). Institutional ethnography and experience as data. *Qualitative Sociology, 21*(1), 55–73. http://dx.doi.org/10.1023/A:1022171325924

Campbell, M. L., & Gregor, F. (2008). *Mapping social relations: A primer in doing institutional ethnography*. University of Toronto Press.

Campbell, M. L., & Rankin, J. M. (2017). Nurses and electronic health records in a Canadian hospital: Examining the social organisation and programmed use of digitised nursing knowledge. *Sociology of Health & Illness, 39*(3), 365–379. https://dx.doi.org/10.1111/1467-9566.12489

Canada Health Act, RSC, 1985, c. C-6. [Canada]. https://www.canlii.org/en/ca/laws/stat/rsc-1985-c-c-6/latest/rsc-1985-c-c-6.html

Canadian Health Coalition. (2018, November). *Policy brief: Ensuring quality care for all seniors*. http://www.healthcoalition.ca/wp-content/uploads/2019/12/Seniors-care-policy-paper-FINAL-Version-Dec-2019.pdf

Canadian Healthcare Association. (2009). *Home care in Canada: From the margins to the mainstream*. https://www.healthcarecan.ca/wp-content/themes/camyno/assets/document/PolicyDocs/2009/External/EN/HomeCareCanada_MarginsMainstream_EN.pdf

Canadian Home Care Association. (2011, April). *Access to quality health care: The home care contribution.* https://cdnhomecare.ca/wp-content/uploads/2020/03/Access-to-Quality-Health-Care-CHCA-June-2011-English.pdf

Canadian Home Care Association. (2018). *Integrated home care and primary health care: A pan Canadian perspective*. Proceedings from the 2018 Home Care Summit panel presentations. https://cdnhomecare.ca/wp-content/uploads/2021/08/Integrated-Home-Care-and-Primary-Health-Care_final-b.pdf

Canadian Home Care Association, Canadian Nurses Association, & College of Family Physicians of Canada. (2016, October). *Better home care in Canada: A national action plan.* https://cdnhomecare.ca/wp-content/uploads/2020/03/Better-Home-Care-Report-web-EN.pdf

Canadian Institute for Health Information. (2017). *Seniors in transition: Exploring pathways across the care continuum*. https://www.cihi.ca/sites/default/files/document/seniors-in-transition-report-2017-en.pdf

Canadian Institute for Health Information. (2019). *National health expenditure trends: 1975 to 2019*. https://www.cihi.ca/sites/default/files/document/nhex-trends-narrative-report-2019-en-web.pdf

Canadian Institute for Health Information. (2020). 1 in 3 caregivers in Canada are distressed. https://www.cihi.ca/en/1-in-3-unpaid-caregivers-in-canada-are-distressed

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada. (2018). *Tri-council policy statement: Ethical conduct for research involving humans: TCPS2 2018*. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

Canadian Nurses Association. (2012). *A nursing call to action: The health of our nation, the future of our health system*. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/2f975e7e-4a40-45ca-863c-5ebf0a138d5e/UploadedImages/documents/NEC_Report_e_Copy.pdf

Canadian Nurses Association. (2013, May). *Optimizing the role of nursing in home health*. https://silo.tips/download/may-30-optimizing-the-role-of-nursing-in-home-health

Canadian Nurses Association. (2014, November). *CNA hill day project summary.* http://www.nationalseniorsstrategy.ca/wp-content/uploads/2015/03/2014-592-CNA-Survey.pdf

Canadian Nurses Association. (2020, May). *2020 vision: Improving long-term care for people in Canada*. https://hl-prod-ca-oc-download.s3-ca-central-1.amazonaws.com/CNA/UploadedImages/05255e6e-9517-43bc-8bc1-f1768316d4e5/Documents/2020-Vision_Improving-Long-Term-Care-for-People-in-Canada_e.pdf

Canadian Nurses Association. (2021). *Nursing statistics.* https://www.cna-aiic.ca/en/nursing/regulated-nursing-in-canada/nursing-statistics

Carrier, A., & Prodinger, B. (2014). Visions of possibility: Using institutional ethnography as a theory and method for understanding contexts and their ruling relations. *Occupational Therapy Now, 16*(2), 18–21.

Ceci, C., & Purkis, M. E. (2011). Means without ends: justifying supportive home care for frail older people in Canada, 1990–2010. *Sociology of Health & Illness, 33*(7), 1066–1080. https://dx.doi.org/10.1111/j.1467-9566.2011.01344.x

Chan, E. A., Jones, A., & Wong, K. (2013). The relationships between communication, care and time are intertwined: A narrative inquiry exploring the impact of time on registered nurses' work. *Journal of Advanced Nursing, 69*(9), 2020–2029. https://dx.doi.org/10.1111/jan.12064

Chappell, N. L. (2011). *Population aging and the evolving care needs of older Canadians: An overview of the policy challenges*. Institute for Research on Public Policy. https://irpp.org/research-studies/population-aging-and-the-evolving-care-needs-of-older-canadians/

Chiu, P. (2021). Advancing nursing policy advocacy knowledge: A theoretical exploration. *Advances in Nursing Science, 44*(1), 3–15. https://dx.doi.org/10.1097/ANS.0000000000000339

Clark, P. G. (2007). Understanding aging and disability perspectives on home care: Uncovering facts and values in public-policy narratives and discourse. *Canadian Journal on Aging, 26*(S1), 47–62. https://dx.doi.org/10.3138/cja.26.suppl_1.047

Community Health Nurses of Canada. (2010). *Home health nursing competencies*. https://www.chnc.ca/en/publications-resources

Community Health Nurses of Canada. (2019). *Canadian community health nursing professional practice model and standards of practice.* https://www.chnc.ca/en/publications-resources

Conference Board of Canada. (2015). *Future care for Canadian seniors*. https://www.conferenceboard.ca/temp/d963624b-2b12-4ffb-842f-73028d107530/8679_Seniors_Care_Nursing_Supply_and_Demand_EN_BR.pdf

Contandriopoulos, D., Stajduhar, K., Sanders, T., Carrier, A., Bitschy, A., & Funk, L. (2021). A realist review of the home care literature and its blind spots. *Journal of Evaluation in Clinical Practice, 28*(4), 680–689. https://dx.doi.org/10.1111/jep.13627

Creswell, J. W., & Creswell, J. D. (2018). *Research design: Qualitative, quantitative, and mixed methods approaches* (5th ed.). Sage.

de Ruiter, H.-P., & Demma, J. M. (2011). Nursing: The skill and art of being in a society of multitasking. *Creative Nursing, 17*(1), 25–29. https://dx.doi.org/10.1891/1078-4535.17.1.25

Demiris, G., Lin, S.-Y., & Turner, A. M. (2019). The role of personal health information management in promoting patient safety in the home: A qualitative analysis. In *MEDINFO 2019: Health and Wellbeing e-Networks for All* (pp. 1159–1163). IOS Press.

Denton, M., Brookman, C., Zeytinoglu, I., Plenderleith, J., & Barken, R. (2015). Task shifting in the provision of home and social care in Ontario, Canada: Implications for quality of care. *Health & Social Care in the Community, 23*(5), 485–492. https://dx.doi.org/10.1111/hsc.12168

Denton, M., Zeytinoglu, I. U., Davies, S., & Lian, J. (2002). Job stress and job dissatisfaction of home care workers in the context of health care restructuring. *International Journal of Health Services, 32*(2), 327–357. https://dx.doi.org/10.2190/vyn8-6nky-rkum-l0xw

Denton, M., Zeytinoglu, I. U, Kusch, K., & Davies, S. (2007). Market-modelled home care: Impact on job satisfaction and propensity to leave. *Canadian Public Policy, 33*, S81–S99. https://doi.org/10.3138/G551-755V-12W7-2551

DeVault, M. L. (2006). Introduction: What is institutional ethnography? *Social Problems, 53*(3), 294–298. https://doi.org/10.1525/sp.2006.53.3.294

DeVault, M. L. (2018). Feminist qualitative research. Emerging lines of inquiry. In N. K. Denzin & Lincoln, Y. S. (Ed.), *The Sage handbook of qualitative research* (5th ed., pp. 176–194). Sage.

DeVault, M. L., & McCoy, L. (2002). Institutional ethnography: Using interviews to investigate ruling relations. In J. Gubrium & Holstein, J. (Ed.), *Handbook of interview research. Context and method* (pp. 751–777). Sage.

Doran, D. M., & Blais, R. (Co-Leads). (2013). *Safety at home: A pan-Canadian home care safety study*. Canadian Patient Safety Institute. https://www.patientsafetyinstitute.ca/en/toolsResources/Research/commissionedResearch/SafetyatHome/Documents/Safety%20At%20Home%20Care.pdf

Duncan, S., & Reutter, L. (2006). A critical policy analysis of an emerging agenda for home care in one Canadian province. *Health and Social Care in the Community, 14*(3), 242–253. https://dx.doi.org/10.1111/j.1365-2524.2006.00616.x

Duncan, S., Thorne, S., & Rodney, P. (2015). Evolving trends in nurse regulation: What are the policy impacts for nursing's social mandate? *Nursing Inquiry, 22*(1), 27–38. https://dx.doi.org/10.1111/nin.12087

Dykes, S., & Chu, C. (2021). Now more than ever, nurses need to be involved in technology design: Lessons from the COVID-19 pandemic. *Journal of Clinical Nursing, 30*(7–8), e25–28. https://doi.org/10.1111/jocn.15581

Fjørtoft, A.-K., Oksholm, T., Delmar, C., Førland, O., & Alvsvåg, H. (2021). Home-care nurses' distinctive work: A discourse analysis of what takes precedence in changing healthcare services. *Nursing Inquiry, 28*(1), 1–10. https://dx.doi.org/10.1111/nin.12375

Funk, L. M., Irwin, P., Kuryk, K., Lobchuk, M., Rempel, J., & Keefe, J. (2022). Home care program flexibility as a relational phenomenon. *SSM – Qualitative Research in Health, 2*, 100107. https://dx.doi.org/10.1016/j.ssmqr.2022.100107

Funk, L. M., & Stajduhar, K. (2013). Analysis and proposed model of family caregivers' relationships with home health providers and perceptions of the quality of formal services. *Journal of Applied Gerontology, 32*(2), 188–206. https://dx.doi.org/10.1177/0733464811408699

Funk, L. M., Stajduhar, K. I., Giesbrecht, M., Cloutier, D., Williams, A. M., & Wolse, F. (2020). Applying the concept of structural empowerment to interactions between families and home-care nurses. *Nursing Inquiry, 27*(1), e12313. https://dx.doi.org/10.1111/nin.12313

Ganann, R., Weeres, A., Lam, A., Chung, H., & Valaitis, R. (2019). Optimization of home care nurses in Canada: A scoping review. *Health & Social Care in the Community, 27*(5), e604–e621. https://dx.doi.org/10.1111/hsc.12797

Garland Baird, L. (2018). *Home care case managers' integrated care of older adults with multiple chronic conditions: An institutional ethnography* [Doctoral dissertation]. University of Alberta. https://era.library.ualberta.ca/items/257ff854-bb38-4f63-8613-c52d8d1b923a/download/a9a3c7a0-5b38-41ac-89cd-4aea1e9221b6

Garland Baird, L., & Fraser, K. (2018). Home care case managers' integrated care of older adults with multiple chronic conditions. A scoping review. *Professional Case Management, 23*(4), 165–189. https://dx.doi.org/10.1097/NCM.0000000000000286

Genet, N., Boerma, W. G. W., Kringos, D. S., Bouman, A., Francke, A. L., Fagerström, C., Melchiorre, M. G., Greco, C., & Devillé, W. (2011). Home care in Europe: A systematic literature review. *BMC Health Services Research, 11*, Article 207. https://dx.doi.org/10.1186/1472-6963-11-207

Gibbon, J. M. (1947). *Victorian order of nurses for Canada: 50th Anniversary 1897–1947*. https://open.library.ubc.ca/collections/bcbooks/items/1.0383341#p16z-6r720f

Gilmour, H. (2018). Unmet home care needs in Canada. *Health Reports, 29*(11), 3–11. https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2018011/article/00002-eng.pdf?st=lRAZ7wuT

Grahame, P. R. (1998). Ethnography, institutions, and the problematic of the everyday world. *Human Studies, 21*(4), 347–360. https://dx.doi.org/10.1023/A:1005469127008

Grypma, S., Wolfs, D., & Reimer-Kirkham, S. (2012). Returning home: Historical influences on home healthcare in Canada. *Home Healthcare Nurse, 30*(8), 453–460.

Hall, S. (Ed.). (1997). *Representation: Cultural representations and signifying practices.* Sage.

Hamilton, P., & Campbell, M. (2011). Knowledge for re-forming nursing's future. Standpoint makes a difference. *Advances in Nursing Science, 34*(4), 280–296. https://dx.doi.org/10.1097/ANS.0b013e3182356b6a

Hamilton, W., Javed, M., Orina, J., Pierce, T., Campbell, C. M., Williams, K., Foots, L., Levenson, J., Robins, K., Hodson, P., McCarthy, M., Patrician, A., & Swiger, P. A. (2023). Components, implementation, and outcomes of a nursing professional practice model: A systematic review. *Nursing Administration Quarterly, 47*(1), 84–93. https://dx.doi.org/10.1097/NAQ.0000000000000554

Hay, S. (2019). Paramedics host drop-in clinics in Toronto community housing buildings. *Global News*. https://globalnews.ca/news/4823055/toronto-paramedics-clinics-tch-buildings/

Health Canada. (2016, April 3). *Home and community health care*. https://www.canada.ca/en/health-canada/services/home-continuing-care/home-community-care.html

Health Council of Canada. (2012). *Seniors in need, caregivers in distress: What are the home care priorities for seniors in Canada?* http://zweb-s3.uploads.s3.amazonaws.com/carp/2012/04/HCC_HomeCare_2d.pdf

Heggestad, A. K. T., Magelssen, M., Pedersen, R., & Gjerberg, E. (2021). Ethical challenges in home-based care: A systematic literature review. *Nursing Ethics, 28*(5), 628–644. https://dx.doi.org/10.1177/0969733020968859

Heitlinger, A. (2003). The paradoxical impact of health care restructuring in Canada on nursing as a profession. *International Journal of Health Services, 33*(1), 37–54. https://dx.doi.org/10.2190/rmay-nja9-kfw7-1uew

Hermus, G., & Stonebridge, C. (2017). *Future care for Canadian seniors: A primer on nursing supply and demand*. The Conference Board of Canada. https://www.conferenceboard.ca/e-library/abstract.aspx?did=8679

Hoe, J., Trickey, A., & McGraw, C. (2022). Caring for people living with dementia in their own homes: A qualitative study exploring the role and experiences of registered nurses within a district nursing service in the UK. *International Journal of Older People Nursing*. Advance online publication. https://doi.org/10.1111/opn.12491

Hollander, M. J., Liu, G., & Chappell, N. L. (2009). Who cares and how much? The imputed economic contribution to the Canadian healthcare system of middle-aged and older unpaid caregivers providing care to the elderly. *Healthcare Quarterly, 12*(2), 42–49. https://dx.doi.org/10.12927/hcq.2009.20660

Hunter, J., Walsh, M., & Howlett, K. (2023, January). Canada's premiers will meet next month with hopes of a health-care agreement breakthrough. *Globe and Mail.* https://www.theglobeandmail.com/canada/british-columbia/article-canadas-premiers-will-meet-next-month-with-hopes-of-a-health-care/

Ibrahim, S., Donelle, L., Regan, S., & Sidani, S. (2020). A qualitative content analysis of nurses' comfort and employment of workarounds with electronic documentation systems in home care practice. *Canadian Journal of Nursing Research, 52*(1), 31–44. https://dx.doi.org/10.1177/0844562119855509

Island Health. (n.d.). *Keeping you safe*. https://www.islandhealth.ca/about-us/accountability/quality-care/keeping-you-safe

Island Health. (2019). *Excellence in health care: Island health 2019 annual report*. http://viha.uberflip.com/i/1202979-island-health-2019-annual-report/0?

Island Health. (2020a). *Documenting a staff safety and awareness planning quick reference guide*.

Island Health. (2020b, July). *Vancouver Island Health Authority (Island Health) 2020/21–2022/23 service plan.* https://www.islandhealth.ca/sites/default/files/reports-and-plans/documents/island-service-plan-2021-2023.pdf

Island Health. (2021). *Island Health performance measures home care professional services*. https://www.islandhealth.ca/sites/default/files/performance-measures/documents/home-care-professional-services.pdf

Jackson, J., Maben, J., & Anderson, J. E. (2022). What are nurses' roles in modern healthcare? a qualitative interview study using interpretive description. *Journal of Research in Nursing, 27*(6), 504–516. https://dx.doi.org/10.1177/17449871211070981

Jakobsen, L. M., & Lind, R. (2022). ´You are not yourself anymore´: The place of the ethical demand in a practical home care context. *Scandinavian Journal of Caring Sciences*. Advance online publication. https://doi.org/10.1111/scs.13076

Johnson, S., Bacsu, J., Abeykoon, H., McIntosh, T., Jeffery, B., & Novik, N. (2018). No place like home: A systematic review of home care for older adults in Canada. *Canadian Journal on Aging, 37*(4), 400–419. https://dx.doi.org/10.1017/S0714980818000375

Johnson, S., Bacsu, J., McIntosh, T., Jeffery, B., & Novik, N. (2017, October). *Home care in Canada: An environmental scan.* Saskatchewan Population Health and Evaluation Research Unit, University of Regina and University of Saskatchewan. https://spheru.ca/publications/files/HomeCare_complexCare_environmental%20Scan18Oct2017.pdf

Jordal, K., Saltveit, V., & Tonnessen, S. (2022). Nursing leadership and management in home care: A qualitative scoping review. *Journal of Nursing Management, 30*(8), 3641–4598. https://doi.org/10.1111/jonm.13872

Kearney, G., Corman, M. K., Hart, N., Johnson, J., & Gormley, G. J. (2019). Why institutional ethnography? Why now? Institutional ethnography in health professions education. *Perspectives on Medical Education, 8*, 17–24. https://dx.doi.org/10.1007/s40037-019-0499-0

Kelly, C., Hande, M. J., Dansereau, L., Martin-Mathews, A., & Williams, A. (2021). Doing 'whatever they can imagine': Social task shifting in directly funded home care. *International Journal of Care and Caring, 5*(3), 393–413. https://doi.org/10.1332/239788220X15984633282891

Lang, A., Edwards, N., & Fleiszer, A. (2008). Safety in home care: A broadened perspective of patient safety. *International Journal for Quality in Health Care, 20*(2), 130–135. https://dx.doi.org/10.1093/intqhc/mzm068

Lang, A., Edwards, N., Hoffman, C., Shamian, J., Benjamin, K., & Rowe, M. (2006). Broadening the patient safety agenda to include home care services. *Healthcare Quarterly, 9*(Sp), 124–126. https://dx.doi.org/10.12927/hcq..18471

Lanoix, M. (2017). No longer home alone? Home care and the Canada Health Act. *Health Care Analysis, 25*(2), 168–189. https://dx.doi.org/10.1007/s10728-016-0336-0

Latimer, J. (2012). Home care and frail older people. Relational extension and the art of dwelling. In C. Ceci, K. Björnsdóttir, & M. E. Purkis (Eds.), *Perspectives on care at home for older people*. Routledge.

Lirette, D. (2019). Kamloops paramedics first in B.C. to receive palliative care training for paramedics. *CBC News.* https://www.cbc.ca/news/canada/british-columbia/kamloops-first-bc-city-palliative-care-training-paramedics-1.5255529

MacAdam, M. (2004). Examining home care in other countries: The policy issues. *Home Health Care Management & Practice, 16*(5), 393–404. https://dx.doi.org/10.1177/1084822304264615

Macdonald, M., Lang, A., Storch, J., Stevenson, L., Donaldson, S., Barber, T., & Iaboni, K. (2013). Home care safety markers: A scoping review. *Home Health Care Services Quarterly, 32*(2), 126–148. https://dx.doi.org/10.1080/01621424.2013.783523

Marrelli, T. M. (2018). What makes home care the most unique practice setting? *Reflections on Nursing Leadership, 44*(1), 73–92.

Martinsen, B., Mortensen, A. S., & Norlyk, A. (2018). Nordic homecare nursing from the perspective of homecare nurses—a meta-ethnography. *British Journal of Community Nursing, 23*(12), 597–604. https://dx.doi.org/10.12968/bjcn.2018.23.12.597

McCoy, L. (2006). Keeping the institution in view. In D. Smith (Ed.), *Institutional ethnography as practice* (pp. 109–123). Rowman & Littlefield.

Melby, L., Obstfelder, A, & Hellesø, R. (2018). “We tie up the loose ends”: Homecare nursing in a changing health care landscape. *Global Qualitative Nursing Research, 5*, 1–11. https://dx.doi.org/10.1177/2333393618816780

Nilsson, K., Lundgren, S., & Furåker, C. (2009). Registered nurses’ everyday activities in municipal health care: A study of diaries. *International Journal of Nursing Practice, 15*(6), 543–552. https://dx.doi.org/10.1111/j.1440-172X.2009.01777.x

Norstedt, M., & Paulsen Breimo, J. (2016). Moving beyond everyday life in institutional ethnographies: Methodological challenges and ethical dilemmas. *Forum: Qualitative Social Research, 17*, 2. https://doi.org/10.17169/fqs-17.2.2539

Oldman, C. (2022). *Behind closed doors - nursing older adults in the home and community.* Paper presented at the Centre for Ageing & Biographical Studies Webinar Series, Open University London.

Ontario Community Paramedicine Secretariat. (n.d.). *History of Ontario Community Paramedicine Secretariat.* https://www.ontariocpsecretariat.ca/about-ocps

Øydgard, G. W. (2017). The influence of institutional discourses on the work of informal carers: An institutional ethnography from the perspective of informal carers. *BMC Health Services Research, 17*(1), 1–12. https://dx.doi.org/10.1186/s12913-017-2591-7

Palmer, K., Stalteri, R., Ongolo Zogo, C., Stall, N., Juni, P., & Law, S. (2022, March). *Home care for older adults during the COVID-10 pandemic: Lessons from the Netherlands, Denmark, and Germany to strengthen and expand home care in Canada*. CanCOVID. https://cancovid.ca/wp-content/uploads/2022/04/CanCOVID-Issue-Note-2-HOME-CARE-FINAL-ENGLISH-1.pdf

Polit, D. F., & Beck, C. T. (2016). *Nursing research: Generating and assessing evidence for nursing practice* (10th ed.). Wolters Kluwer.

Purkis, M. E. (2001). Managing home nursing care: Visibility, accountability and exclusion. *Nursing Inquiry, 8*(3), 141–150. https://doi.org/10.1046/j.1320-7881.2001.00105.x

Purkis, M. E., Ceci, C., & Björnsdóttir, K. (2008). Patching up the holes: Analyzing the work of home care. *Canadian Journal of Public Health, 99*, S27–S32. https://dx.doi.org/10.1007/BF03403801

Queen's Nursing Institute. (n.d.). *Safe caseloads in the district nursing service.* https://qni.org.uk/nursing-in-the-community/district-nurse-caseloads/

Quinlan, E. (2009). The 'actualities' of knowledge work: An institutional ethnography of multi-disciplinary primary health care teams. *Sociology of Health & Illness, 31*(5), 625–641. https://dx.doi.org/10.1111/j.1467-9566.2009.01167.x

Rankin, J. (2017). Conducting analysis in institutional ethnography: Guidance and cautions. *International Journal of Qualitative Methods, 16*(1), 1–11. https://dx.doi.org/10.1177/1609406917734472

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

Riekert, S. A. (2021). The home healthcare nurse: A concept analysis. *Home Healthcare Now, 39*(4), 194–202. https://dx.doi.org/10.1097/NHH.0000000000000961

Romanow, R. J. (2002, November). *Building on values: The future of health care in Canada*. http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf

Sadusky, J. M., Martinson, R., Lizdas, K., & McGee, C. (2010). The praxis safety and accountability audit: Practicing a "sociology for people." *Violence Against Women, 16*(9), 1031–1044. https://dx.doi.org/10.1177/1077801210379374

Sandberg, L., Borell, L., & Rosenberg, L. (2021). Risks as dilemmas for home care staff caring for persons with dementia. *Aging & Mental Health, 25*(9), 1701–1708. https://dx.doi.org/10.1080/13607863.2020.1758914

Schofield, R., Ganann, R., Brooks, S., McGugan, J., Dalla Bona, K., Betker, C., Dilworth, K., Parton, L., Reid-Haughian, C., & Watson, C. (2011). Community health nursing vision for 2020: Shaping the future. *Western Journal of Nursing Research, 33*(8), 1047–1068. https://dx.doi.org/10.1177/0193945910375819

Scott, S. M., & Scott, P. A. (2021). Nursing, advocacy and public policy. *Nursing Ethics, 28*(5), 723–733. https://dx.doi.org/10.1177/0969733020961823

Sharkey, S., Larsen, L., & Mildon, B. (2003). An overview of home care in Canada: Its past, present, and potential. *Home Health Care Management & Practice, 15*(5), 382–390. https://dx.doi.org/10.1177/1084822303252401

Sharkey, S., & Lefebre, N. (2017). Bringing nursing back to the future through people-powered care. *Nursing Leadership, 30*(1), 11–22. https://dx.doi.org/10.12927/cjnl.2017.25110

Sharkey, S., Lefebre, N., Ray, K. L., Scott, T., & The Saint Elizabeth First Nations Inuit and Métis Team. (2020). Home health nursing in Canada. In L. L. Stamler, L. Yui, A. Dosani, J. Etowa, & C. van Daalen-Smith (Eds.), *Community health nursing: A Canadian perspective* (5th ed., pp. 74–87). Pearson.

Smith, D. E. (1987). *The everyday world as problematic: A feminist sociology*. University of Toronto Press.

Smith, D. E. (1990). *The conceptual practices of power: A feminist sociology of knowledge*. Northeastern University Press.

Smith, D. E. (1999). *Writing the social: Critique, theory, and investigations*. University of Toronto Press.

Smith, D. E. (2003). Making sense of what people do: A sociological perspective. *Journal of Occupational Science, 10*(1), 61–64. https://dx.doi.org/10.1080/14427591.2003.9686512

Smith, D. E. (2004). Ideology, science and social relations: A reinterpretation of Marx's epistemology. *European Journal of Social Theory, 7*(4), 445–462. https://dx.doi.org/10.1177/1368431004046702

Smith, D. E. (2005). *Institutional ethnography: A sociology for the people.* Alta Mira Press.

Smith, D. E. (2006a). Incorporating texts in ethnographic practice. In D. Smith (Ed.), *Institutional ethnography as practice*. Rowman & Littlefield.

Smith, D. E. (2006b). *Institutional ethnography as practice*. Rowman & Littlefield.

Smith, D. E., & Griffith, A. (2022). *Simply institutional ethnography: Creating a sociology for people*. University of Toronto Press.

Smith, G. W., Mykhalovskiy, E., & Weatherbee, D. (2006). Research proposal. In D. Smith (Ed.), *Institutional ethnography as practice* (pp. 165–179). Rowman & Littlefield.

Smith Higuchi, K. A., Christensen, A., & Terpstra, J. (2002). Challenges in home care practice: A decision-making perspective. *Journal of Community Health Nursing, 19*(4), 225–236. https://dx.doi.org/10.1207/S15327655JCHN1904_03

Stajduhar, K., & Contandriopoulos, D. (2018). *Tackling the home care challenge: A mixed methods study of publicly funded home care services in 4 Canadian cities* (CIHR Research Proposal). Canadian Institutes of Health Research.

Statistics Canada. (2021). *Census Profile*, *2021 Census of Population.* https://www12.statcan.gc.ca/census-recensement/2021/dp-pd/prof/index.cfm?Lang=

Statistics Canada. (2022, August 26). *Home care use and unmet home care needs in Canada, 2021.* https://www150.statcan.gc.ca/n1/daily-quotidien/220826/dq220826a-eng.htm

Strandås, M., Wackerhausen, S., & Bondas, T. (2019). The nurse–patient relationship in the New Public Management era, in public home care: A focused ethnography. *Journal of Advanced Nursing, 75*(2), 400–411. https://dx.doi.org/10.1111/jan.13850

Suhonen, R., Stolt, M., Habermann, M., Hjaltadottir, I., Vryonides, S., Tonnessen, S., Halvorsen, K., Harvey, C., Toffoli, L., & Scott, P. A. (2018). Ethical elements in priority setting in nursing care: A scoping review. *International Journal of Nursing Studies, 88*, 25–42. https://dx.doi.org/10.1016/j.ijnurstu.2018.08.006

Thompson, N. (2022). Staffing shortages hitting beleagured home care sector. *CBC News*. https://www.cbc.ca/news/canada/toronto/ontario-home-care-pandemic-staffing-1.6325192

Tourangeau, A., Patterson, E., Rowe, A., Saari, M., Thomson, H., MacDonald, G., Cranley, L., & Squires, M. (2014). Factors influencing home care nurse intention to remain employed. *Journal of Nursing Management, 22*(8), 1015–1026. https://doi.org/10.1111/jonm.12104

Trudeau, J. (2019). *Minister of health mandate letter*. https://pm.gc.ca/en/mandate-letters/2019/12/13/minister-health-mandate-letter

Turner, S. M. (2006). Mapping institutions as work and texts. In D. Smith (Ed.), *Institutional ethnography as practice* (pp. 139–161). Rowman & Littlefield.

Underwood, J., Baumann, A., Akhtar-Danesh, N., MacDonald-Rencz, S., MacDonald, M., Matthews, S., … Ciliska, D. (2009). *National community health nursing study: Comparison of enablers and barriers for nurses working in the community*. https://fhs.mcmaster.ca/nhsru/documents/SeriesReport14NationalCommunityHealthNursingStudyComparisonofEnablersandBarriersforNursesWor.pdf

Underwood, J. M., Mowat, D. L., Meagher-Stewart, D. M., Deber, R. B., Baumann, A. O., MacDonald, M. B. R., Akhtar-Danesh, N., Schoenfeld, B. M., Ciliska, D. K., Blythe, J. M., Lavoie-Tremblay, M., Ehrlich, A. S., Knibbs, K. M., & Munroe, V. J. (2009). Building community and public health nursing capacity: A synthesis report of the National Community Health Nursing Study. *Canadian Journal of Public Health, 100*(5), I1–11. https://dx.doi.org/10.1007/BF03405282

Wadhwani, A. (2019, January 30). B.C. paramedics to be trained in at-home care for seriously ill, end-of-life patients. *Surrey Now Leader*. https://www.surreynowleader.com/news/b-c-paramedics-to-be-trained-in-at-home-care-for-seriously-ill-end-of-life-patients/

Walby, K. (2007). On the social relations of research: A critical assessment of institutional ethnography. *Qualitative Inquiry, 13*(7), 1008–1030. https://dx.doi.org/10.1177/1077800407305809

Walby, K. (2013). Institutional ethnography and data analysis: Making sense of data dialogues. *International Journal of Social Research Methodology, 16*(2), 141–154. https://dx.doi.org/10.1080/13645579.2012.661207

Waters, N. R. (2016). *The social organization of wound clinic work: An institutional ethnography* [Doctoral dissertation]. University of Calgary. http://dx.doi.org/10.11575/PRISM/28383

WorkSafe BC. (2008). *Occupational Health and Safety Regulations: Part 4: General conditions: Working alone or in isolation*. https://www.worksafebc.com/en/law-policy/occupational-health-safety/searchable-ohs-regulation/ohs-regulation/part-04-general-conditions#SectionNumber:4.20.1

World Health Organization. (2020, April 6). *State of the world's nursing 2020: Investing in education, jobs & leadership*. https://www.who.int/publications/i/item/9789240003279

Appendix A: Ethics Approval

University of Victoria

Certificate of Ethical Approval: Amendments for Harmonized Minimal Risk Behavioural Study

University of Victoria
Human Research Ethics Board

Also reviewed and approved by:

- **Island Health**

Principal Investigator: Kelli I. Stajduhar	**Primary Appointment:** Faculty, University of Victoria	**Board of Record REB Number:** BC19-0142	**REB Number:** H19-00561
Study Title: Tackling the Home Care Challenge: A Mixed Methods Study of Publicly Funded Home Care Services in 3 Canadian cities			
Approval Date: November 16, 2020		**Expiry Date: April 16, 2021**	
Research Team Members:	Della K Roberts, Island Health Annie Carrier, Universite de Sherbrooke Laura Funk, University of Manitoba Damien Contandriopoulos, Faculty, University of Victoria Susan Duncan, Director, School of Nursing, University of Victoria Ivy Bourgeault, University of Ottawa Ami Bitschy, Project Coordinator, University of Victoria Tanya Sanders, Post-doctoral fellow, University of Victoria Jill Gerke, Island Health		
Sponsoring Agencies:	- Canadian Institutes of Health Research (CIHR)		

Documents included in this approval:

Document Name	Version	Date
Protocol:		
Appendix A_ Study Protocol	1	October 27, 2020
Consent Forms:		
Appendix 7 - Observation Consent_HCSP	3	November 16, 2020
Appendix 8 - Interview Consent	3	November 16, 2020
Assent Forms:		
Appendix 6 - Observation Assent Script_HCC_HCSP	3	November 16, 2020
Advertisements:		
Appendix 11 - Recruitment Presentation_HCSP	2	November 16, 2020
Appendix 10 - Recruitment Poster_HCSP	2	November 16, 2020
Appendix 16 - Key Statements_HCSP	1	October 27,

Appendix B: Observation Consent Form

Tackling the Home Care Challenge: A Multi-Site Mixed Methods Study of Publicly Funded Home Care Services in 3 Canadian Cities

University of Victoria | Institute on Aging & Lifelong Health

Observation Consent – Home Care Service Provider

Funding for this research was provided by:	*Principal Investigators from the University of Victoria:*
Canadian Institutes for Health Research	Dr. Kelli Stajduhar, RN, PhD Dr. Damien Contandriopoulos, PhD

Background and Purpose of the Study

We are looking at the relationship between best practices in home care and the Canadian experience. In particular, we are looking to observe and interview 15-30 home care service providers, such as yourself, in each of three provinces, B.C., Manitoba, and Québec. Through these observations and interviews, we will document and compare the home care experience taking into account "on the ground" concerns. At the same time, we will collect information on the best working home care models around the world. These two streams of research will be used to provide a recommendation document to help develop home care that promotes consistent and fair access to meet the needs of an ever-increasing number of home care clients in Canada.

You have been invited to participate because of your current professional role (home care manager, home care nurse) in providing publicly funded home care within one of the three selected sites included in this study, you have been practicing for more than 6 months, and you work more than 10 shifts a month. Your participation is completely voluntary and you may withdraw at any time.

What is involved?

Upon agreement to participate, you will be asked to:

- Fill out a short demographics questionnaire to allow us to collect such information as your education, experience, and cultural background (this will be collected via phone or using a University Zoom account);

- Allow a researcher to job shadow you in your home care office (they will not be observing you while traveling or while you are at clients homes) for 3-5 consecutive days. They will be taking detailed field notes on any care discussions, actions, and/or tasks that you perform as you carry out your work duties. They may ask simple questions to clarify a statement or instruction, for example, should you be following up on your last medication discussion, they might ask when and/or how that discussion occurred.
- Receive instruction (~10 minutes) on how to inform a virtual client of your participation in this study as ask for permission that the researcher might observe the visit (this will be done via phone or University Zoom account);
- Be contacted after the observation period is complete to participate in a 60-minute interview (this will be done remotely using phone or a University Zoom account) around your experiences regarding changes in home care service delivery, particularly the barriers and facilitators to this service. You will be re-consented at that time.

The researcher **will not** criticize or judge your work, observations **will not be shared** with the health authority or the client. Taking part in this study will not affect your employment with the health authority in any way.

Risks and Benefits:

If at any time you find the observation intrusive, upsetting, or interfering with care, you may request the researcher to leave temporarily, or withdraw altogether, without consequence. If you identify gaps in care or knowledge, we invite you to share this with us as we may have resources available to assist in your practice.

There may or may not be direct benefits to you from taking part in the study. However, findings and recommendations will be shared with government and health authorities to improve the planning and coordination around home care services.

COVID-19 Risks and Specific Safety Measures:

While there are no risks associated with the collection of demographics, there are inherent risks if you should choose to participate in the observation (job shadowing) portion of this study. To help mitigate risks of COVID-19 exposure all research staff will be following a detailed COVID-19 Safety Plan along with any required COVID-19 protocols that are already in place within your home health office. In general, only one researcher will be paired with each home care office, this researcher will be wearing the appropriate and required PPE at all times, will carry disinfectant wipes on their person, will be maintaining proper distancing whenever possible, and has agreed to reduce their community engagement over the observation period. Should yourself, or the researcher, develop any symptoms of COVID-19 observations will be paused until such a time as the recommended isolation or testing is complete. The research coordinator will be in close communication with the leadership at your home care office to monitor the COVID-19 situation throughout this study. If at any time the health authority should ask that the observations be halted or postponed you will be notified immediately.

Do I have to take part?

You are free to participate or not. There are no consequences to not participating. Joining this study does not waive any of your legal rights to research-related harm. If you decide to participate and then change your mind later, you can withdraw without any consequences or explanation. If you choose to withdraw from the study, we will ask for your permission to use the data (observation notes, demographic form) already collected up to that point in our analysis

Will I receive payment for taking part?

You will not receive any monetary benefits for your participation. All time spent on this project will be during work hours and thus is compensated for by your health authority.

Confidentiality and data storage

You will be given a unique number; your name will not be included in any field notes or other study data documents. A key code document, which links your name to your data, will be kept by the study coordinator in a separate digital space to that of the study data. Your unique number will be used on all information collected during the course of this study, so that your identity [your name or any other information that could identify you] will be kept confidential. If you are taking part in other parts of this study (i.e. the subsequent interview), this number will link your data. Only the project staff will be able to see the raw information gathered (researcher observing your work, the project coordinator, Ami Bitschy, and the project leads - Kelli Stajduhar and Damien Contandriopoulos). Other members of the research team may review the notes, but only after all identifying information has been removed. None of the data collected will be shared with anyone in Island Health or any other health care agency. One year after the study is complete the key code (which links your identity to your participant data) will be deleted.

Participant anonymity and confidentiality for COVID-19 exposure and contact tracing:

To ensure proper contact tracing protocols and allow for a quick response to any suspected or tested COVID-19 cases among research staff and participating Island Health staff, the research team at the University of Victoria will maintain a contact tracing file which will contain your name and contact information as well as any dates and times you have been in contact with your paired research team member. This file will be stored separately from any data collected and will be kept on the UVic encrypted server that is only accessed by specific UVIC employees with password access. In the same way it is anticipated that you, as a research participant, will ensure that your research pair is contacted by yourself or someone else from your office should you believe yourself to be exposed or test positive for COVID-19.

All files are stored in a locked office, on encrypted computers at the University of Victoria and only a few people on the research team have access. Any reports or presentations made from the findings of this study will not use your name or other details that could reveal your identity.

Future use of data

Following CIHR-funding guidelines, researchers will retain digital de-identified data sets indefinitely. The retained electronic data from this study will be kept for future graduate students and/or further secondary analyses by Drs. Stajduhar or Contandriopoulos. Research ethics approval will be sought before any secondary analysis is done. Data will be stored securely at the University of Victoria and in compliance with the highest standard of data management practices.

Disposal of study documents and recordings

One year after the study is complete the key code (which links your identity to your participant data) will be deleted. We will scan all paper copies of field notes and save them electronically. 5 years after the completion of the study we will shred all paper notes and delete any electronic files with identifying information. All de-identified electronic documents will be kept indefinitely on the secured and password protected servers at the University of Victoria.

Sharing the Findings:

We plan to share what we have learned from our study in many ways. We will write a final report that will be shared with all participants, give presentations and workshops in the community or over video-conferencing platforms (such as Zoom, Skype), and provide the provincial and federal governments with a recommendations document based on our findings. We will present our findings at national and international meetings and conferences. Our results may be published in academic journals and/or public newspapers, which may be available online.

Who should I contact if I need more information or help?

For more information about the research, please contact Ami Bitschy, project coordinator at [telephone number] or [email address]. You may also contact the University of Victoria principal investigators directly – Kelli Stajduhar, [telephone number] or [email address] or Damien Contandriopoulos, [telephone number] or [email address].

For questions or concerns about your rights as a research participant, please contact the Human Research Ethics Office at the University of Victoria at [telephone number] or [email address].

CONSENT

Your emailed consent indicates that:

1. All sections of this Consent form have been explained to your satisfaction,
2. You understand the requirements, risks, potential, and responsibilities of participating in this research project,
3. You understand your responsibility to the research team to communicate with your researcher pair if you believe yourself to be exposed or test positive for COVID-19;
4. You understand how your information will be accessed, collected and used, and
5. Your questions have been answered by the researcher or project coordinator.

Please retain a copy of this consent form for your records – an emailed confirmation of consent will be accepted by the researcher.

Appendix C: Interview Consent Form

Tackling the Home Care Challenge: A Multi-Site Mixed Methods Study of Publicly Funded Home Care Services in 3 Canadian Cities

University of Victoria | Institute on Aging & Lifelong Health

Interview Consent – Leadership & Practitioner

Funding for this research was provided by:

Canadian Institutes for Health Research

Principal Investigators from the University of Victoria:

Dr. Kelli Stajduhar, RN, PhD

Dr. Damien Contandriopoulos, PhD

Background and purpose

We are looking at the relationship between best practices in home care and the Canadian experience. In particular, we are looking to interview service providers, and key informants with knowledge and expertise around the current state of home care in each of three provinces, B.C., Manitoba, and Québec. Through these interviews, we will document and compare the home care experience taking into account "on the ground" and other administrative and funding concerns. At the same time, we will collect information on the best working home care models around the world. These two streams of research will be used to provide a recommendation document to help develop home care that promotes consistent and fair access to meet the needs of an ever-increasing number of aging and chronically ill home care clients in Canada.

You have been invited to participate because:

1. Your current professional role is to provide and/or direct publicly funded home care within one of the three selected sites included in our study and you have previously participated in this study through observations in your workplace and/or site visits; **or**
2. You have been identified by your colleagues as:
   a. Someone who provides and/or directs publicly funded home care within one of the three selected research sites; and
   b. Someone who has integral insight that should be captured and included in our study.

Your participation is completely voluntary and you may withdraw at any time.

What is involved?

Upon agreement to participate, you will be asked to:

- Fill out a short demographics questionnaire to allow us to collect such information as your education, experience, and cultural background (this will be collected via phone or using a University Zoom account);
- Participate in a 60-minute interview around your experiences regarding changes in home care service delivery, insights into where the barriers are in home care, and what facilitates the delivery of home care services – especially to those who are aging and/or chronically ill. The interview will be held on a day/time that works for you. This will be audio recorded. Some types of questions we might ask include, "what is your position, what are you responsible for in home care?", "what are some system impacts you see as a result of people 'aging in place'?" (this will be done via phone or using a University Zoom account);
- Remain in contact for a short time after the interview, should we require any clarification around the information that you provided.

Risks and benefits

There are no anticipated risks related to your participation in this study. Some people may find themselves embarrassed, uncomfortable, or anxious when sharing their experiences. However, people who have participated in our past studies have often found it helpful to share and relate their point of view. You do not have to answer any question and there are no right or wrong answers; we are seeking your opinion and insights. If at any time you find the interview intrusive, or upsetting you can request a short break or end the interview altogether without consequence. There may or may not be direct benefits to you from taking part in the study. We expect to share findings with government and health authorities to impact planning and coordination around home care.

Do I have to take part?

You are free to participate or not. There are no consequences to not participating. Joining this study does not waive any of your legal rights to research-related harm. If you decide to participate and then change your mind later, you can withdraw without any consequences or explanation. If you choose to withdraw, we will ask for your permission to use the answers you have already provided up until that point in our analysis.

Will I receive payment for taking part?

You will not receive any monetary benefits from participating in this observation.

Confidentiality and data storage

You will be given a unique number; your name will not be included in any field notes or other study data documents. A key code document, which links your name to your data, will be kept by the study coordinator in a separate digital space to that of the study data. Your unique number will be used on all information collected during the course of this study, so that your identity [your name or any other information that could identify you] will be kept confidential. If you are taking part in other parts of this study (i.e. the subsequent interview), this number will link your

data. Only the project staff will be able to see the raw information gathered (researcher observing your work, the project coordinator, Ami Bitschy, and the project leads - Kelli Stajduhar and Damien Contandriopoulos). Other members of the research team may review the notes, but only after all identifying information has been removed.

All files are stored in a locked office, on encrypted computers at the University of Victoria and only a few people on the research team have access. Any reports or presentations made from the findings of this study will not use your name or other details that could reveal your identity.

Future use of data

Following CIHR-funding guidelines, researchers will retain digital de-identified data sets indefinitely. The retained electronic data from this study will be kept by future graduate students and/or for further secondary analyses by Drs. Stajduhar or Contandriopoulos. Research ethics approval will be sought before any secondary analysis is done. Data will be stored securely at the University of Victoria and in compliance with the highest standard of data management practices.

Disposal of study documents and recordings

One year after the study is complete the key code (which links your identity to your participant data) will be deleted. All audio recordings will be transcribed and the original audio recordings will be deleted once data collection is complete. 5 years after the completion of the study we will shred all paper notes and delete any electronic files with identifying information. All de-identified electronic documents will be kept indefinitely on the secured and password protected servers at the University of Victoria.

Sharing the findings

We plan to share what we have learned from our study in many ways. We will write a final report that will be shared with all participants, give presentations and workshops in the community or over video-conferencing platforms (such as Zoom, Skype), and provide the provincial and federal governments with a recommendations document based on our findings. We will present our findings at national and international meetings and conferences. Our results may be published in academic journals and/or public newspapers, which may be available online.

Who should I contact if I need more information or help?

For more information about the research, please contact Ami Bitschy, project coordinator at [telephone number] or [email address]. You are also welcome to contact the University of Victoria principal investigators directly – Dr. Kelli Stajduhar: [telephone number]; [email address] and/or Dr. Damien Contandriopoulos: [telephone number]; [email address].

For questions or concerns about your rights as a research participant, please contact the Human Research Ethics Office at the University of Victoria at [telephone number] or [email address].

CONSENT

Your emailed consent indicates that:

1. All sections of this Consent form have been explained to your satisfaction,
2. You understand the requirements, risks, potential and responsibilities of participating in this research project,
3. You understand how your information will be accessed, collected and used, and
4. Your questions have been answered by the researchers.

Please retain a copy of this consent form for your records – an emailed confirmation of consent will be accepted by the researcher.

Appendix D: Study Infographic and Recruitment Information Posters

HOME CARE RESEARCH STUDY
Service Providers WANTED

Are you a home care service provider [***case manager or nurse***] who directs and provides care to clients?

Have you been working in home care for over 6 months, and do you currently work a minimum of 10 shifts per month?

Drs. Kelli Stajduhar and Damien Contandriopoulos, from the University of Victoria, Institute on Aging & Lifelong Health, are seeking 15-30 home care service providers for a Canadian study of best practices and models of home care delivery. We are NOT evaluating your individual work, but compiling a better understanding of how home care works.

Participation would involve:

- Having a researcher 'job shadow' you in the home care office environment for 3 – 5 consecutive shifts (they will observe your work & may ask some clarifying questions throughout).
- A 60-minute interview around your insight/experiences of how home care is currently structured in BC.

Our CIHR IRSC funded project will run for 4 years and involves two components

Component 1: a focused review of home care services in Canada & other developed countries

Component 2: Institutional ethnography (observation & documentation) of home care practices in 3 sites across the country; Victoria BC, Winnipeg MB, and Sherbrooke QC.

INTERESTED?

Ami Bitschy, MSc
Project Coordinator – UVic:
[Email address]
[Phone number]

University of Victoria | Institute on Aging & Lifelong Health

version 2 – November 16, 2020

Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke

TACKLING THE HOME CARE CHALLENGE

A Multi-Site Mixed Methods Study of Publicly Funded Home Care Services in 3 Canadian Cities

PROJECT SUMMARY

ABOUT THE PROJECT

Island Health is participating in a national study to better understand the current realities in home care practice in Canada. This study is led by Dr. Kelli Stajduhar from the School of Nursing and Institute on Aging and Lifelong at the University of Victoria and also includes study sites in Winnipeg, MB and Sherbrooke, QC. Jill Gerke, Director and Della Roberts CNS with the Palliative & End of Life Care program are part of the research team. A key outcome of the project will be recommendations to inform the development of sustainable home care service delivery models to meet the needs of aging and chronically ill populations across Canada.

WE NEED YOUR HELP

The best way to understand how home care is currently delivered is to learn from those who work in home care. The institutional ethnography (conducted within a select number of CHS offices on Vancouver Island) considers the question from a specific perspective, and initially we are considering the case manager and home care nurse position. These interviews & observations will assist our team to understand the factors, policies, and practices that currently and historically shape home care at the health unit and organizational levels. We will also be interviewing various key informants once the interviews & observations with home care case managers and nurses are complete.

We seek participation in a phased approach, given the continued pandemic response and planning. This revised plan will enable physical distancing while recognizing the capacity pressures that currently exist within community health services.

Phase 1 – Interviews with Home Care Case Managers and Nurses

We would ask that you participate in a 60-90min audio-recorded **interview** (phone or zoom) to provide us with a clear understanding of your current work and how it pertains to the care provided to clients at home. Our intent is **not to evaluate your practice** but to understand how and why home care works the way it does, and what factors and/or local context influence the delivery of home care.

During the interview, we will ask you to help us identify key documents (e.g., policies, procedures, clinical assessment tools, administrative documents, correspondence) that are used in the everyday work in your home care setting.

Phase 2 – Job Shadowing with Home Care Case Managers and Nurses

Once COVID-19 restrictions are lifted in BC, we will re-contact you to ask about the possibility of physically distanced 'job shadowing' with a member of our research team. They will observe you while you work in the office throughout one full set of shifts (3-5 consecutive days) (days and amount of time to be negotiated based on your capacity and willingness – all required Island Health COVID-19 guidelines will be followed). We would like the opportunity to observe you in your everyday work within your home care office, in your interaction with colleagues, during any communications and virtual visits with clients.

Phase 3 - Key Informants

We are hoping to conduct audio-recorded (zoom or telephone) key informant interviews in Home and Community Care with allied health clinicians, administrators, managers, and/or clinical leaders. The purpose of these interviews is to develop a fuller understanding of the factors that have and currently influence the delivery of home care.

Thank you for considering our request. As the project progresses you will be able to find more information on the following website: https://www.uvic.ca/research/groups/peol/current-research/thcc. *If you have any questions or would like to participate in this research please contact the project coordinator, Ami Bitschy*, at [Telephone Number]; [Email address].

Sincerely,

Jill Gerke, Director
Palliative and End of Life Care
Island Health
[Email address]

Della Roberts, Clinical Nurse Specialist
Palliative and End of Life Care
Island Health
[Email address]

Appendix E: Level 1 Participant Interview Guide

Tackling the Home Care Challenge: A Multi-Site Mixed Methods Study of Publicly Funded Home Care Services in 3 Canadian Cities

Interview Guide – Home Care Service Provider

Funding for this research was provided by:

Canadian Institutes for Health Research

Principal Investigators from the University of Victoria:

Kelli Stajduhar, RN, PhD

Damien Contandriopoulos, PhD

Preamble

The overall goal of our project is to better understand the current and historical influences on home care services, especially as they relate to aging people with or without chronic life-limiting illness. We have invited you to be interviewed because of your position and expertise in the management and/or provision of home care services. We remind you that your participation must be free and voluntary. You are welcome to skip any questions you do not wish to answer, and we remind you that we will be recording this interview. Upon transcription your name will be replaced with a unique identification number. Our final report will not include any identifying information and although we might use quotes, any data we present will be de-identified and reported in aggregate, or combined, form.

- Was there anything you wanted to go over in the consent form, do you have any questions?
- Would you mind taking a few minutes to go through the Demographics form with me before we start the interview?

Okay now that the demographics are out of the way, we can begin the interview. Once I hit the record button the first thing I will ask is that you provide me with verbal consent. Ready?

[Hit record and ask for verbal consent on the audio recording – then begin]

Questions

1. To begin, can you tell me a little bit about your position and how it relates to the services and care provided in the home (home care)?

   Prompts

   a. Can you describe your role?
      a) In relation to clients/families
      b) In relation to Home care Nurses/ Case Managers – staff at the home care office
   b. If you were to write a job description – list the 4 or 5 main items you would include (work wise)
   c. What are the services offered by your position, written/unwritten?

2. Walk us through a day at work, try to describe your thoughts and actions in as much detail as possible.

   Prompts

   a. You arrive at the office, what is the first thing you do, is there anything you do before you arrive at the office for your work?
   b. Imagine you are just about to sit down and begin this task (process, item, etc…) how do you begin?
   c. What steps did you take, what was your thinking/planning (things we might not see) along the way?
   d. What decisions or actions might you complete, how did you know to do this, how was this documented?
   e. What documents/texts/procedures influenced this work?
   f. Was anybody else involved in the work you are describing?
      a) Who was involved and why?
      b) How was this work communicated with others?

3. We would like to unpack your work with the home care team as it relates to this particular [encounter/task/item] that you mentioned. Think back on this [encounter/task/action]. Walk me through the steps/actions that were taken, describe your work.

   Prompts

   a. What type of encounter was this (meeting, visit, phone call)?
      a) How/why was this encounter initiated in the first place (what is the reason behind the call/visit/meeting, were there any particular client and/or family circumstances that precipitated this)
   b. Who was involved in assigning this work to you?
      a) How do you know that you need to meet with this client on this day, at this time?

b) What procedures, processes or documents (paper, electronic) were accessed or required to get this in place?

c. Think about how you prepare for the encounter…

a) How do you plan (do you have a mental/physical list of steps you use when doing this particular encounter with a client – have you altered this in some way to fit the situation and if so why – based on what)?

b) What is in place to help you prepare for this work (forms, documents, guidance, advice)

c) If you are planning a home visit – are there any extra steps or processes that must be considered / done (i.e. do you do anything to prepare directly before you enter the home and immediately….).

d. Describe the encounter …

a) You are with the client – let's paint the room.

i. Who's with you?

ii. Why is each person there?

iii. What are you doing (physically, mentally) as you meet and work with this client? Do you have anything with you to help you work – in your hands, pockets (tools, forms, documents, binders, experience – knowledge)?

b) Walk me/us through the encounter… be sure to note what you were doing, how you were doing it, and why you were doing it that way.

i. As you walk through this work – try to mention any items (forms/texts-policy-guides/tools/knowledge) that you are using in your work, are you using anything physically in your hands or mentally.

ii. What actions did you take?

1. What documentation, forms, resources were you using, completing or needing to fill out/submit because of this work?

2. Where do these forms go next – who are they shared with?

c) Were there any particular client and/or family circumstances that you encountered during your visit that influenced how you went about your work?

i. If so, please describe these circumstances?

1. What were the factors that influenced/ guided/directed your action(s) ?

2. What forms, documents, policies, procedures were followed to guide this work?

e. You have just finished with this meeting/call/visit… now what do you do?

a) What is the first thing you do and why?

b) Are there any follow up actions required?

i. Where is this work done (office, car, head)?

ii. What documentation, forms, resources will you need, are there any forms/documents that now require completion/submission as a result of the work done with the client?
   1. Where do the forms go once completed/submitted?

iii. Are any other staff clients involved in this follow up work?

4. You had mentioned [larger system issue] when describing our work. Can you elaborate a bit more on this…
   a. Can you think of any historical or local reasons why this might be the case?
   b. Where do you think accountability might lie for this piece?

Permission for observations

Possible themes to be covered in questions:

Priority and demand – describe the referral process

Assessment and intervention

Home support, security, and autonomy

Professional mandates

Effectiveness / Efficiency / Productivity

Ethical elements

Quality improvement processes

Health records: priorities, waiting lists, ownership, and closure.

Thank you for taking time to meet with us. It is possible that I might reach out for a bit more clarification around something we discussed here today? Are you okay for me to send an email or give you a call? Is there anything else you would like to add? If you think of anything later please don’t hesitate to connect with me via email or phone – my information [the project coordinators] is provided on the consent form.

Appendix F: Level 2 Participant Interview Guide

Level 2 Questions

Guiding Questions:

Please tell me about your work – the role you have and what you do in Community Health Services. Clarify and prompt further responses on their work.

Itinerary Sheets – threads

- What is the purpose of these?
- Where did these come from? How were they created/come to be?
- What is recorded what isn't?
- What happens to these after they are filed in the binder?
- Prompts re: safety – scheduling visits – how are they "supposed" to be used

- What is your work with scheduling client care?
- Staffing –what influences your decisions around allocation of nurses in staffing?
- How is staffing determined – float/casual assignments (workload)
- How are caseloads determined for nurses?
- Time allocation to types of clients/needs – are their guidelines around this for nurses? Typical times and how are these shared?
- How has PowerChart, the move to electronic documentation, impacted scheduling for nurses?

Possible follow-ups

What led to the name change Home and Community Care to Community Health Services?

Why/Influences/Implications

What clinical supports are there for nurses working with clients who are living with chronic illness (vs. supports for palliative)

How is it determined what clients receive home visits/services at home from nursing versus what clients will be asked to come into the clinic to receive nursing services? What happens if people aren't able to come into the clinic who are deemed clinic clients?

Appendix G: Tackling the Home Care Challenge Observation Guide

Tackling the Home Care Challenge: A Multi-Site Mixed Methods Study of Publically Funded Home Care Services in 3 Canadian Cities

OBSERVATION GUIDE – HOME CARE SERVICE PROVIDER

Funding for this research was provided by:

Canadian Institutes for Health Research

Local Lead Researcher - University of Manitoba:

Dr. Laura Funk, PhD

Field note guide for observations:

Context:	Where does the observation take place? When? What is the physical layout?
People:	Who is present? Why are they here?
Situation:	Is this a home visit, an interdisciplinary meeting, a telephone call, or working in the office, etc…?
Actions:	What is the provider doing? Observable behaviours, involving documents or potentially indicative of the problem under study (e.g., recurrences)
Questions / Points to investigate:	What are the elements that should be addressed in an informal follow up or formal interview?
Timing / Order:	What is the order of things? What might be the reasons for this order?
Goals :	What is the provider trying to accomplish?

The notes will be reviewed by the research team. Notes will not be shared with research participants. These written notes must be kept at the local University in a locked filing cabinet within a locked office. Once transcribed and coded, they must be scanned and saved in electronic form, and the papers must be shredded according to the study's data destruction protocols.

Provider Observation Guide
Researcher: ____________________
Participant Number/s: ____________________ *Dates :* ___/___/___

Context / People	Situation	Actions of the Provider	Questions / Points to Investigate

Situation: home visit, interdisciplinary meetings, telephone call or writing in the office, etc.; Actions: observable behaviours, involving documents or potentially indicative of the problem under study (e.g., recurrences); Questions/Items to be investigated: elements to be addressed during formal or informal interviews.

Provider Observation Guide
Researcher: ____________________
Participant Number/s: ____________________ *Dates :* ___/___/___

Guide to Informal Follow-Up/Clarification Questions:

If you don't mind, we'll "unpack" step by step what you've done (with client X, in situation X). To do this, I will guide you through some simple questions. Don't be surprised if I stop you in the middle of your explanation. This is to make sure I understand every detail you've thought of in your head. You may not be able to answer my questions. This is normal, since much of what you do is automatic or even unconscious. We will try to put into words what you are doing. If you can't, I'll guide you to another question. Is that okay with you?

- Describe to me what you did (with client X, in situation X)
- Explain to me what guided your choices

<<PROBES >>

and when
while continuing to
what is this/that?
what happened after?
while/ during
and at that moment?

Based on observed actions and your answers to the previous questions, could I get a bit more detail around some of the following?

- When you do this[1] (action), what are you really doing?
  What leads you to this particular (action)?
- When you use this (document), what are you doing?
  What brought you to use this particular (document)?
- You have told me that (such and such[2]) guides your (action).
  What are the other elements, if any, guide your (action/s)?
- How does this (action) influence, if at all, your subsequent (action/s)?
- (Who) or (what document / regulation / guideline / policy / procedure), if any, would be able to provide me with more information on (this aspect)?

[1] In order to optimize the observed action/experience and in alignment with the principles of descriptive interviews, the questions pertaining to the details of the action are done in present time.

[2] Action: documentary symbol (legal, regulatory or administrative aspects) or organisational aspects of the practice context.

Document Grid
Researcher/Site: ______________________
Participant Number/s: _______________ *Dates :* ___/___/___

Title of document	Type of document	General purpose	Description of direct role	Description of indirect role

Type of document (e.g., law, regulation, administrative policy, form, etc.); General purpose: goals or objectives explicitly named in the document; Direct role: use made (verbally or physically) by the Provider, as observed by the researcher or reported by the Provider; Indirect role: referenced in a document that has a direct or reported role in relation to organizational aspects of the practice context. Smith (2006) refers to this role as regulating the organization of the microsystem, among other things through documents used directly in the participants' work.

Guide for field notes following observations
Researcher/Site : ____________________
*Participant Number/s:*__________________ *Dates :* ___/___/___

Guide for Field Notes to be Recorded Following Observations:

Date:	
Location:	
Participant Codes:	
Observer:	

Section 1: Observational Notes
These notes are descriptive accounts of your observations as a third-party observer. In this section, you will describe the type of things detailed in the observation guide. One way to think of these field notes is as a descriptive story. Make your field notes as descriptive and detailed as you can. The more colorful and clear they are the more the rest of the research team will be able to visualize what you are describing.

Section 2: Reflexive Notes
These are your own reflection on the observation. Be sensitive to your own bias and avoid making generalizations. Also reflect on your own professional and social positioning that may have influenced the research process, participants' reactions to you as an observer, and the dynamics of your relationship with participants. Describe any personal feelings/interpretations that you may have based on the observation, relating it to other observations if applicable. Also make note here of questions that should be asked in interviews and any themes that you're seeing.