Nurses' Perspectives on How Operational Leaders Influence Function-Focused Care for Hospitalized Older People

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Abstract

Aims. To explore nurses' perspectives on how leaders influence function-focused care (FFC), defined as care that preserves and restores older people's functional abilities.

Background. Hospitalized older people are at risk of functional decline. Although leaders have the potential to influence FFC, few studies explored nurses' perspectives on how leaders influence FFC.

Methods. Thirteen focus groups were held with 57 acute care nurses. Semi-structured questions prompted discussion on nurses' perspectives, needs and strategies to meet their needs. Data were thematically analyzed.

Results. Three themes were identified: 1) the emphasis in hospitals is on moving older people quickly through the system, not supporting their functioning; 2) leaders are generally seen as too disconnected from practice to design system efficiency initiatives that support older people's functioning and nurses' provisioning of FFC; and 3) leadership strategies to better support nurses in providing FFC to older people in the context of system efficiency.

Conclusions. Leaders should connect with practice to devise age-sensitive efficiency initiatives that support FFC. Nurses need support from leaders in four areas to provide FFC to older people in the current hospital context.

Implications. Findings provide direction on how leaders can facilitate FFC in the current healthcare environment emphasizing system efficiency.

Keywords: Acute care, Function-focused care, Healthcare system efficiency, Operational leaders, Older people

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Background

Up to 46% of older people admitted to hospital experience functional decline or loss in the ability to independently perform activities of daily living (Zisberg et al. 2015). Functional decline is one of the most disabling and life altering risk factors associated with an older person's hospitalization (Covinsky et al. 2011), and has been linked to iatrogenic complications, institutionalization (Portegijs et al. 2015), death (Buurman et al. 2011), and higher costs of care (Asmus-Szepesi et al. 2014) in this patient population. Because of the small window of opportunity in which older people can restore lost functioning and resume their former lives after hospital discharge (Walsh et al. 2011), preventing functional decline is a priority in countries with an aging population.

Function-focused care (FFC) is an approach to older people's care that is designed to prevent these adverse consequences. FFC is provided alongside the active management of an acute episode to mitigate the negative effects that common treatments and practices have on older people's functioning (Kresevic & Palmer 2015). In this approach, which is used in North America (Fox et al. 2012) and elsewhere (de Man-van Ginkel et al. 2015), nurses assess older people's functional abilities and, based on their assessments, provide interventions to preserve and/or restore functioning (Fox et al. 2013). Nurses also collaborate with inter-professional team members in coordinating care to optimize older people's functioning. For example, nurses communicate any declines in older people's functioning to team members so that treatments restricting functioning can be modified and rehabilitation can be promptly initiated (Fox et al. 2013). Similarly, nurses collaborate with teams in preparing older people and families for

discharge so that they can function at home. Because operational leaders (i.e., unit managers, directors and administrators; hereafter, called leaders) are responsible for cultivating practice environments that support nurses in providing and coordinating care (Twigg & McCullough 2014), they are critical to nurses' provision of FFC.

While prior studies on FFC identified the importance of unit managers to nurses' ability to promote older people's functioning (Boltz et al. 2011; Doherty-King & Bowers 2013), no studies have explored nurses' perspectives on what they need from their leaders to promote patient functioning. Moreover, prior studies only examined physical functioning (Boltz et al. 2011; Doherty-King & Bowers 2013). Yet, cognitive and psychosocial functioning are also central tenets of FFC (Kresevic & Palmer 2015) and therefore critical to the preservation and restoration of functional abilities.

Previous studies on leadership found that the practices of managers, directors and administrators influenced patient (Wong & Giallonardo 2013) and nurse outcomes (Hayes et al. 2012) but few investigated leadership practices or behaviors that influence FFC or other nursing practices. Also, prior studies examined nurses' perspectives of nurse leaders to the exclusion of non-nurse leaders (Wong et al. 2013) who also have the potential to influence nurses' provision of FFC.

Aims

In order to expand this body of knowledge, this study aimed to explore nurses' perspectives on how their leaders influence FFC, what nurses need from leaders to provide FFC, and to identify strategies to meet those needs. Understanding nurses' perspectives can provide important insights into leadership practices to support nurses in optimizing older people's functioning during an acute hospital stay.

Methods

A qualitative descriptive design was used to produce a comprehensive, interpretive summary of nurses' perspectives and to identify leadership strategies that facilitate nurses' provisioning of FFC Focus groups (FGs) were conducted to promote participant interaction and elaboration of views (Krueger & Casey 2014). The study was approved by the Ethical Review Board at XXXYork University, Certificate #: e-2011-318

Sample

FGs were held with a purposeful criterion-based sample of 57 nurses drawn from a list of 2005 nurses who had completed a survey on care of older people and provided their permission to be contacted for a FG. Eligible nurses were registered nurses (RNs) and registered practical nurses (RPNs) working in Ontario acute care hospitals. As presented in Table 1, participants worked in a variety of practice settings, such as emergency departments (ED) and general medical, surgical, and intensive care units.

Participant Selection and Data Collection

FGs were initially organized so that participants had the same professional designation (RN and RPN) and hospital teaching status to ensure homogeneity within groups. Thirteen FGs were held with 33 RNs and 24 RPNs. FGs had an average of five nurses (range three to seven), with telephone FGs having fewer respondents (Krueger & Casey 2014). Six participants withdrew from the study due to scheduling conflicts. Eight FGs were homogenous, held face-to-face with four strata: two with RNs working in teaching hospitals, two with RNs working in non-teaching hospitals, two with RPNs working in teaching hospitals, and two with RPNs working in non-teaching hospitals. When no major differences emerged between these strata, an

additional five heterogeneous FGs were conducted with nurses from all four strata. To mitigate logistical and geographic barriers to participation, these five FGs were conducted by telephone.

A previously pilot tested semi-structured interview guide was used in the FGs. Questions were developed based on the nursing care practices of a function-focused model of care (Fox et al. 2013) and prompted participants to discuss what nurses need from their leaders to provide FFC and to identify strategies to meet those needs (e.g. "what kind of support do you as nurses need from administrators, managers, and directors so that you can provide FFC to older people?"). Probes were used to elicit detailed examples of specific leadership behaviors that help nurses to provide FFC.

To generate discussion, the moderator (JB) encouraged participants to interact, respond to, and build on each other's views and comments, and share similar or different perspectives and experiences. FGs lasted from 75-140 minutes. Field-notes and methodological memos were recorded. During data collection, new data were continuously compared to prior FG data. FGs were held until data saturation was achieved, which was determined when data became redundant and no new descriptive codes, categories, or themes were identified (Gentles et al. 2015).

Data Analysis

Data analysis was conducted concurrently with data collection. FG audio-recordings were transcribed verbatim. Data were analyzed using inductive thematic analysis (Guest et al. 2011). This process involved listening to recordings, reading transcripts and field-notes, and coding for surface and latent meanings of text segments. A codebook was created that defined each code. We then grouped similar codes and developed categories. Through an iterative process that involved interpreting and revisiting categories, we refined these categories into larger unifying

themes. Differences in themes based on professional designation (RN versus RPN) and the status of nurses' primary hospital (teaching versus non-teaching) were examined. Differences that were identified are reported. Strategies for trustworthiness are described in Table 2.

Findings

Three major themes of equal importance were identified: 1) the emphasis in hospitals is on moving older people quickly through the system, not supporting their functioning, 2) leaders are generally seen as too disconnected from practice to design system efficiency initiatives that support older people's functioning and nurses' provisioning of FFC, 3) leadership strategies to better support nurses in providing FFC to older people in the context of system efficiency. Themes are depicted in Figure 1.

[Figure 1 about here]

Participants addressed leadership at numerous levels. They predominantly discussed their managers, but also referenced "CEOs," "administrators," "supervisors," "management" and "department heads." Participants were conscious that not all system efficiency initiatives were devised by managers alone but rather by leaders as a collective. Consequently, their recommendations were sometimes specific to managers and at other times were directed towards leaders more generally.

The emphasis in hospitals is on moving older people quickly through the system, not supporting their functioning

This theme captures the organizational context in which nurses strive to provide FFC to older people. Participants agreed, with great frustration, that "pushing older patients through" is now a "global issue" in hospitals. The priority is maximizing efficiency by assessing, treating,

and discharging older patients as quickly as possible. As one RPN stated candidly, "the number one goal is to get these [older] people out, in whatever condition." An RN elaborated:

> Everyone's talking now about patient flow [uh-huhs and nods of agreement from group]. The elderly are caught up in that. They have to be out…They might need another day...A year ago, we could say sure, give them another day. Now's it's the flow. Off they go. It's at work in all the departments. The flow. The flow. (General surgical unit, teaching hospital)

This fixation was understood as rooted in the high costs of older people's care and the potential for them to languish indefinitely in hospitals. Government-spearheaded financial disincentives were seen as motivating leaders to achieve system-level targets, such as reduced time in the Emergency Department (ED) and shorter hospital stays, rendering older people's functioning low-priority. One RN explained that "their [leaders'] focus is fiscal, wherever they've got to report back to the government. [But] they're not responsible for reporting back in terms of effective care of the elderly." This emphasis on system efficiency also narrowed healthcare providers' attention to older people's acute medical issues, to the exclusion of the bigger picture of their functioning. In this context, older people were seen as highly vulnerable and rapidly "going downhill." One RPN asserted "leadership, they need to sit down and look at what we do can to tackle this issue" because, in treating older patients:

> We fix the immediate problem but do not ask what we can do to create an environment for these [older] people so they can go back to normal functioning…give them the support to get them strong and send them home. (Intensive care unit, teaching hospital)

Participants expressed the need for leaders to recognize the tenuousness of older people's functional abilities. Yet, as our next theme conveys, leaders' ability to do so was seen as limited.

Leaders are generally seen as too disconnected from practice to design system efficiency initiatives that support older people's functioning and nurses' provisioning of FFC

Participants acknowledged that leaders are under immense pressure to make the system more efficient. However, they saw leaders as too disconnected from practice to fully appreciate older people's functional vulnerability and devise age-sensitive system efficiency initiatives. Characterized as "closed off in their offices," "lost in spreadsheets," and "removed from patients," leaders were perceived as "not understanding geriatrics." Leaders were criticized for lacking knowledge of how aging processes impact recovery from acute illnesses or injuries, and for mistakenly assuming that older people's needs are identical to those of younger patient populations. One RN explained how leaders take for granted that "everybody's the same...[But] the 90-year-old with a gall bladder surgery is a heck of a lot different from the 16-year-old with the gall bladder surgery…I think that's where the problem is." Consequently, the initiatives that leaders devised directly and indirectly undermined older people's functioning.

In discussing direct effects, one RPN noted that the government's disincentive of deducting funds from hospital budgets when ED stays are over eight hours spurred her manager to circumvent this disincentive by moving "patients around to keep them out of the ED…they may be moved four or five times." These multiple transfers were observed to be extremely "stressful" and "disorienting" to older patients, undermining their cognitive functioning and putting them at risk for delirium. In terms of initiatives that indirectly jeopardized older people's functioning by curtailing nurses' ability to provide FFC, participants spoke of being managed like "factories." For instance, they described "tick sheets" where nurses record the care activities they performed. Tick sheets were characterized as a "corporate initiative" whose use has

escalated and gotten to be "just too much," infringing upon nurses' time to provide FFC. One RPN described her hospital's "hourly sign-in sheet" as a:

> Waste of time that could be used for other valuable things. We have to sign in every patient, seven patients, every hour. That's 84 times I have to sign my name and check off three different spots…older patients don't get walked. (General medical unit, non-teaching hospital)

Participants spoke of leaders' efforts to boost productivity by maximizing nurses' time at the bedside. For example, nurses' attendance at inter-professional rounds was described as increasingly de-prioritized. Instead, only a "charge nurse" attended rounds, relaying information between nurses and inter-professional teams. Positioning charge nurses as go-betweens was described as ineffective because crucial information about changes in older people's functioning was seen as regularly getting "filtered," "lost," and "not reaching" team members who could initiate or modify interventions to restore functional losses. This approach also limited nurses' ability to contribute detailed knowledge of their patients' day-to-day functioning to team decision-making and planning.

Participants recommended that leaders, especially managers, become more knowledgeable about and connected with practice around older people's functioning. Doing so would improve leaders' ability to devise system efficiency initiatives that do not directly or indirectly undermine older people's functioning. Learning first hand by coming to the units and leveraging nurses' knowledge by soliciting their input were perceived as vital in developing such understanding.

Leadership strategies to better support nurses in providing FFC to older people in the context of system efficiency

Participants perceived that, because of a fiscally constrained healthcare system and an aging population, leaders would continue to be under pressure to improve its efficiency which, in turn, would continue to pressure nurses to process older people through the system with maximum efficiency. To help nurses provide FFC in this context, nurses need leaders to: Facilitate inter-professional team accessibility in FFC, take charge of family-nurse conflicts around FFC, mobilize help for the physical aspects of FFC, and equip nurses for FFC.

Facilitate inter-professional team accessibility in FFC. Although they spoke positively about inter-professional team collaboration and they insisted that the team is integral to FFC, participants were very dissatisfied with the team's "limited" and "inflexible" accessibility. Inaccessibility was particularly problematic "over the weekend," when there are "just as many admissions" but less staff, and frail older people are more likely to sustain functional losses. One RPN explained that "if you have a problem in the evening…geriatric support is not there." Another similarly described how "on Mondays, it's like the really sick kind of got debilitated more over the weekend." Participants maintained that they are unable to replace the unique contributions of inter-professional team members in FFC, yet, are "expected to cover all of these other disciplines," referring predominantly to physical therapists but also to occupational therapists. Participants thus recommended that leaders re-examine inter-professional team members' accessibility.

Take charge of family-nurse conflicts around FFC. Participants emphasized the importance of managers and supervisors who act as the "go-to person" during conflicts surrounding FFC and "diffuse any sort of major issues with family members." Because of the drive to discharge older people quickly, participants recognized the importance of involving family members in FFC. One RN asserted:

> In our geriatric population, they're [families] that key piece to help link us back to the community and get that patient back home and back to their previous kind of functioning. [But] they don't have that same level of knowledge you [nurses] do…so they may not understand our rationale for using certain interventions. It's incredibly important to do some teaching to help them understand why we take a certain approach. (ED, teaching hospital)

Despite efforts to educate family members, some were seen as still not understanding FFC. As a result, participants described getting "a lot of pushback from family" who resist FFC. They described family members who would telephone and instruct nurses not to get their older relatives out of bed, and others who would put them "back to bed" as soon as the nurses got them up. One RPN noted with exasperation that some family members insisted on:

> Feeding people who don't need to be fed. Let them feed themselves because part of their rehab is feeding themselves...help them participate in their care so that we can get them out of here and get them home. We want them back functioning. (General surgical unit, non-teaching hospital)

The behaviors of some such families were described as escalating to the point of "being abusive" to nurses. When managers and supervisors took charge of these conflicts, participants felt supported in providing FFC. An RPN explained that when: "that family member's daughter keeps yelling at us…our manager will say, ok, I'm going to address the situation. So just hearing that and knowing…that we're not just left to fend for ourselves, is very, very, very important."

Mobilize help for the physical aspects of FFC. Participants described the physical aspects of FFC as "heavy" and "difficult," requiring "manpower" and "muscle." They explained how

they often "need help but help is not available," contributing to the neglect of care tasks fundamental to preserving older people's functional abilities. One RPN described how:

> "You're supposed to get them up in the chairs, you're supposed to take them and walk them…But very often older patients will be in that bed 24 hours…you can't get them out of bed…you don't have anyone to help you." (General medical unit, non-teaching hospital)

Consequently, participants recommended that "management" allocate more human resources to the physical care of older patients.

Equip nurses for FFC. Participants asserted that, for nurses to provide FFC, managers should provide nurses with continuing education opportunities to help them perform new roles imposed upon them within a system stressing efficiency. Participants perceived an erosion of in-hospital services that had previously prepared older patients and families to function at home after discharge, leaving nurses to shoulder the majority of tasks related to discharge. With this expanded scope of practice, participants recognized their lack of knowledge around discharge planning, and there was uncertainty about whether they were "doing it right."

Also, limited access to geriatric equipment that is essential for FFC was found to be pervasive. A trend was noted where participants working in non-teaching hospitals described being particularly lacking in equipment - "rickety commodes," "horrible wheel chairs that are breaking down" and "old antiquated beds" were recurringly cited as impeding FFC. They indicated that they lacked geriatric equipment, such as electronic wandering bracelets and bed alarms to keep track of older patients who are "very restless" and insist on walking. As a result, many participants admitted begrudgingly resorting to practices that undermine older people's

functioning, such as restraining them or moving them into the hallway at night where they could be monitored at the risk of experiencing poor sleep and confusion.

Discussion

This study contributes to the burgeoning literature on FFC for older people which, to the best of our knowledge, has failed to examine nurses' perspectives on leadership. Findings shed light on how nurses are constrained in providing FFC in an environment where leaders are preoccupied with improving efficiency. Increasing efficiency of the healthcare system is a major concern for policymakers in every industrialized country (Nigam et al. 2014). Out of 11 industrialized countries, the United States ranked last and Canada 10th in overall healthcare system efficiency, followed by Germany, France, the Netherlands and Switzerland (Davis et al. 2014). In this context, initiatives to maximize throughput or flow and minimize resource use (Nayar et al. 2012) are widespread, and their development is a key leadership role (Reid & Dennison 2011). Findings have relevance to these countries, all of which are experiencing population aging (United Nations 2013).

While prior studies have identified a tension between system efficiency and overall quality of care, they have only done so from the perspectives of leaders (Orvik et al. 2014; Udod & Care 2013). In contrast, our study illuminates nurses' perspectives on how leaders and nurses are challenged in reconciling these competing priorities in a specific type of care that is especially relevant to older people. Specifically, our findings add to a thread in the literature reporting on the unintended negative consequences of efficiency initiatives. Studies in this vein have argued that prioritizing efficiency pulls nurses' attention away from practice, pushing them to work to forms (Porter-O'Grady & Malloch 2015). This shift may thwart nurses' ability to

prevent functional decline and related complications in older people, ultimately decreasing throughput and increasing resource use through increased hospital readmissions.

An equally important consequence of the drive for efficiency is that it disengages leaders from practice. Engaged leaders are required at all levels of the healthcare system, particularly at the point of care (Griffith 2012). Our finding that nurses view leaders as disengaged and want more engaged leaders, particularly managers, corroborates other research (Rouse 2009). In prior studies, engaged leaders were extolled by nurses for promoting positive collaborations, human relations, and work environments (Anonson et al. 2014). However, unlike these studies, our study uniquely reveals the need for leaders to connect to practice so that they may learn about older people's functional precariousness and be better prepared to competently apply that knowledge when developing system efficiency initiatives. This finding underscores the need to expand current conceptualizations of nurse practice environments that support older people's functioning, which, to date, have focused on institutional values for older people, geriatric resources and inter-professional collaboration as key components (McKenzie et al. 2011). The pivotal role of engaged and knowledgeable leaders in supporting older people's functioning merits further inquiry.

Especially worrisome are the unintended consequences that efficiency initiatives may have for older people's functional outcomes. For example, multiple transfers, such as those aimed at keeping older people out of the ED, are known risk factors for delirium (Goldberg et al. 2015). Delirium, one of the most frequent conditions experienced by older hospitalized people, is associated with higher costs of care (Leslie et al. 2011), declines in self-care, longer hospital stays, mortality, and permanent cognitive impairment in this patient population (Salluh et al. 2015).

Wong (2015) highlighted the urgent need for research that advances understanding of effective leadership behaviors and the mechanisms by which leaders influence patient outcomes. Our study provides preliminary evidence on the mechanisms by which leaders may influence older patient's functional outcomes, and which can serve as the conceptual basis for future studies. We show how leaders' disconnection from practice can lead them to design system efficiency initiatives that directly and indirectly undermine older people's functioning. Beyond highlighting the need to create better opportunities for nurses to help leaders appreciate older people's functional vulnerabilities and design age-sensitive system efficiency initiatives, our study identifies four leadership behaviors that, in the current context, support nurses in providing FFC to older people: 1) enabling interprofessional team accessibility, 2) taking charge of family-nurse conflicts around FFC, 3) mobilizing help, and 4) equipping nurses for FFC.

First, a key finding of this study is the limited availability of inter-professional team members to nurses. Because functional decline can begin within 48 hours of older people's admission to hospital (Puthucheary et al. 2013), leaders should increase inter-professional team availability by reorganizing their work hours. Similarly, our finding that efficiency initiatives limit nurses' presence at inter-professional team rounds, resulting in care decisions being made with limited nurse input, concurs with a report by Lees (2013). In FFC, nurses' contribution of information about patient functioning is especially essential to effective and efficient team decision-making. Patient care and system efficiency goals are not mutually exclusive. Rounds have the potential to reduce length of hospital stay and improve patient flow (Zaubler et al. 2013), thereby reducing costs (Lane et al. 2013). Consequently, we recommend that managers support nurses' presence at inter-professional rounds.

Second, the need for leaders to take charge of family-nurse conflicts dovetails with previous research that found nurses frequently have to contend with family conflicts (Edwards et al. 2012). It is in these instances that managers and supervisors should step in to prevent nurses' provision of FFC from being derailed. Leaders may also need to support nurses in learning how to involve families whose lack of understanding of FFC may cause them to impede nurses' efforts (Boltz et al. 2015).

Third, our finding that nurses require more help to perform physical aspects of FFC is consistent with prior research (Boltz et al. 2011). Although further investigation is needed, it is possible that unregulated healthcare workers may facilitate the physical aspects of FFC in fiscally constrained healthcare environments.

Last, nurses' limited access to geriatric equipment that is essential for FFC was found to be pervasive, but particularly problematic in non-teaching hospitals. Limited equipment may be related to the reduced funding for equipment that smaller community hospitals, which tend to be non-teaching, receive relative to larger teaching hospitals in Ontario (Ontario Medical Association 2010). This finding has important implications for Canada's healthcare system, which is comprised predominantly of non-teaching hospitals, several of which are located in non-urban regions with disproportionately more older people who have poorer functional health and greater risk of disability relative to their urban counterparts (Walker & Lead 2011). Our finding that nurses perceive they are increasingly responsible for discharge planning, yet feel ill-equipped to provide it, concurs with previous research (Graham et al. 2013). Accordingly, leaders should prioritize continuing education to enable nurses to competently assume discharge planning, thereby maximizing the ability of older patients and families to function at home.

Limitations

The study sample was limited to nurses. Future research is needed to understand the perspectives of leaders around FFC for acutely ill or injured older people. Similarly, further exploration of nurses' perspectives on specific types of leaders is required. FG participant demographic data did not include information on ethnicity or socio-economic background that may have demonstrated patterns in participant responses. The study was limited to Canada. Findings may not be generalizable to other jurisdictions in which improving healthcare system efficiency is not as high a priority.

Conclusions

Nurses perceive that moving older people efficiently through the system is the priority in hospitals and leaders are under immense pressure to improve efficiency. However, nurses view leaders as out of touch with practice, and, consequently, the initiatives they implement to improve efficiency undermine older people's' functioning and nurses' capacity to provide FFC. Learning about older people's care was recommended to help leaders devise system efficiency initiatives that enable FFC. Nurses perceive that because of a fiscally constrained healthcare system and an aging population, they will continue to be under pressure to process older people through the system with maximum efficiency. To help nurses provide FFC in this context, they need leaders to facilitate inter-professional team accessibility, take charge of family-nurse conflicts around FFC, mobilize help for the physical aspects of FFC, and equip nurses for FFC.

Implications for Nursing Management

We urge leaders at all levels to carefully consider how the imperative of efficiency shapes their work and that of nurses. With an aging population, it is crucial that leaders recognize the pitfalls of system efficiency superseding FFC, and make older people's functional outcomes a high priority. We suggest that administrators establish targets for older people's functional

outcomes and create incentives that encourage managers, directors, and supervisors to achieve them. We also recommend that leaders connect to care to better appreciate the functional vulnerabilities of older people and the challenges nurses face in providing FFC. This connection will enhance leaders' competence in devising system efficiency initiatives that support nurses in providing FFC and, ultimately, optimize both patient- and system-level outcomes. Managers can use the findings to provide nurses with the supports they need to provide FFC to older people. Our recommendations extend beyond FFC and may inform the overall implementation of initiatives to improve leadership more generally.

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Conflict of Interest

The authors declare no conflicts of interest.

Table 1

Demographic and Work Related Characteristics of Focus Group Participants (n=57)

Characteristic	n	%
Gender		
Female	54	94.7
Male	3	5.3
Age		
25-34	6	10.5
35-44	13	22.8
45-54	19	33.3
55-64	17	29.0
65 or older	2	3.5
Highest level of education in nursing		
RPN diploma	24	42.1
RN diploma	22	38.5
Baccalaureate degree in nursing	11	19.2
Professional designation		
RPN	24	42.2
RN	33	57.8
Years of nursing experience		
10 years or less	22	38.5
11 years or more	35	61.5
Primary area of practice		
Emergency	7	12.2
General medicine	22	38.5
General surgery	9	15.7
Intensive care	8	14.0
Coronary care	4	7.1

Non-critical care specialty	1	1.7
Multiple units	6	10.5
Employment status		
Casual	4	7.1
Part-time	9	15.7
Full-time	44	77.1
Hospital status		
Teaching	21	36.8
Non-teaching	36	63.2

Note. n = sample size; RN = registered nurse; RPN = registered practical nurse.

Table 2

Strategies Used for Trustworthiness

Quality criterion	Provisions made by researchers
Credibility	- Data triangulation via different types of participants (RNs and RPNs working in teaching and non-teaching hospitals) and different practice settings - Tactics to help ensure honesty and encourage diverse opinions from respondents, such as building rapport, explaining that there are no right or wrong answers, and emphasizing that data will be kept confidential - Adoption of appropriate, well recognized research methods - Iterative questioning in data collection dialogues - Negative case analysis to explore and integrate data contradicting coalescing patterns by actively seeking out and discussing deviant cases during verification and conclusion-drawing. Matrices were used to identify frequencies and patterns of association in participants' narratives for each theme. - Peer scrutiny of the study - Examination of other research to frame this study's findings
Transferability	- Provision of participant demographic and work-related data to establish context of study and allow comparisons to be made - Purposive sampling of participants with different professional designations and from different practice settings - In-depth methodological description to allow study to be replicated
Dependability	- Stepwise replication involving independent analysis by two researchers and comparison of findings - Code-recode strategy at two different time periods
Confirmability	- In-depth methodological description to allow integrity of research findings to be scrutinised - Recording an audit trail - Researcher reflexivity

Note. Table adapted from Shenton (2004).