RESTORATIVE CARE UNIT: A FOCUSED ETHNOGRAPHY OF LEADERSHIP IN A 20-BED HOSPITAL

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Abstract

The creation of a restorative care unit (RCU) within an acute care environment caused a change in the nursing team relationships that impacted leadership and culture of the RCU. A focused ethnographic approach provided insight into the nursing team members' (registered nurses [RNs], registered practical nurses [RPNs] and personal support workers [PSWs]) shared experiences, and the contextual factors that impacted the culture of the RCU. Critical Social Theory and intersectionality (Hankivsky & Christoffersen, 2008) provided the theoretical basis for the study design, data collection and data analysis for understanding the experiences on the RCU. This study found four themes: (1) uncertainty within a new intersection; (2) working together emerges from within; (3) leading within the hierarchy; and (4) everyone contributing within a team. The implications for practice, policy and research include PSWs being an integral part of the nursing team, need for more RCUs, and examining best place for RCUs.

Dedication

I would like to dedicate this thesis to my amazing husband, Glenn, who has stood by me throughout this journey, offering support and encouragement; and to my three beautiful children, Anna, Tony and Jeremy who have been my cheerleaders throughout these past few years. All of you inspire me to be the best that I can be.

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Also, thank you Dr. Elsabeth Jensen for encouraging me to switch to the thesis route for my masters when I struggled to finding meaning in the course-based route. This took me down a path where my passion for making a difference in nursing practice has come to life through research.

I would also like to thank the hospital and the participants at the hospital who were willing to share their stories about working on the restorative care unit. You welcomed me into your unit and allowed me to build my skills as a novice researcher. Without each of you, I would not have been able to capture the leadership practices, relationships that influenced the culture of your restorative care unit.

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Chapter 1

Introduction

In Canada, a universal healthcare system exists where all of the provinces and territories have control over healthcare service delivery and the federal government provides financing and ensures adherence to the Canada Health Act (Marchildon, 2005). In Ontario, the Ministry of Health and Long-term Care (MOHLTC) is responsible for healthcare delivery. In most of the provinces and territories, the delivery of healthcare services is divided into geographical areas. In Ontario, there are 14 Local Health Integration Networks (LHINs) and the LHIN's mandate is to plan, integrate, and fund healthcare services (Marchildon, 2005).

In Ontario, the healthcare system is changing because of the added complexity of care that exists with the increased number of older adults. In 2009, the number of older adults (65 years and higher) in Ontario was 13.6% and it is expected to increase to 23.4% by 2036 (Ministry of Finance, 2010). In addition, chronic disease management, and rising healthcare costs have required the LHINs to change their focus from hospital funding to funding home and community support services and innovative projects that promote preventative and wellness services (MOHLTC, 2012). Therefore, there is an increased need for PSW services for the growing seniors' population in Ontario (Health Professions Regulatory Advisory Council [HPRAC], 2006). PSWs work in a variety of healthcare settings: long-term care (LTC), community, and hospitals. In Ontario, it is estimated that 57,000 PSWs work in LTC; 34,000 in the community; and 6,000 work in hospitals (HPRAC, 2006).

In October 2011, a small rural, 20-bed hospital opened a restorative care unit (RCU) with the assistance of the Local Health Integration Network (LHIN) one-time funding. The RCU is a new restorative care program that promotes receiving care as close to home as possible with

increased access to healthcare, in particular, restorative care with the primary focus of patients returning home (MOHLTC, 2012). In a recent survey, the Canadian Housing and Mortgage Corporation (2008) reported that 85% of people aged 55 years or older wanted to age at home (p. 2). Restorative care refers to a philosophy of care that focuses on evaluating the older adults' capability with regard to functional and physical activity and helps them to optimize, maintain or regain their independence, focuses on health and not illness, and assists to transition patients back to their homes (Resnick, 2012, p. 4). Therefore, the RCU provides a care service for the older adults in the community and the surrounding region.

A limited number of RCUs exist across the different regions across in Ontario. The uniqueness of the RCU in this study is that it is embedded within an acute care unit. The nursing team has gone through a transition with each other creating a new working environment, which changed the culture of the hospital. The new work environment has created new relationships and leadership experiences for the nursing team members.

In this thesis, I will explore the relationships and leadership experiences from the perspectives of the nursing team, and how these factors influence the culture of the RCU. The nursing team is composed of RNs, RPNs and PSWs. This exploration of the RCU culture will also provide insight into how this can study can inform nursing practice. The rationale for a study about leadership will be described, followed by a literature review about what is known about nursing practice in RCUs and the factors that influence the nursing work environment; such as relationships, conflict, and teamwork. The methodology section includes the steps, procedures, and strategies for gathering and analyzing the in-depth qualitative data. In addition, the theoretical framework will provide a guideline for the interpretation of the findings. In the

findings section, I will identify themes that emerged and then discuss the findings in relation to current literature and implications for nursing practice, policy and research.

Rationale for Study

As a RN who holds a position as a Director of Care in a long-term care facility, I have a keen interest in gerontology and nursing practice. In my career, I have worked as a health care aide, RPN and RN and I am now working in a leadership position. I understand that nursing team relationships have an influence on the culture of the units they work in. For my study, I did not include patients as part of the research because I wanted to focus specifically on the nursing team members experiences of leadership on the RCU. I chose the RCU because it has an RPN Leader who works with PSWs within an acute care environment. The nursing team roles have expanded and leadership skills have made the RCU what it is. In addition, having read the literature extensively, I became aware that there is limited research on RCUs, more specifically, the nursing perspectives on relationships and how this impacts leadership and culture of the unit. Thus, I feel that the nursing team has stories to share and an ethnographic study would explore the day to day leadership practices of the RCU and provide a perspective of the culture. Thus, my research project would fill the gap in the current nursing literature.

During a preliminary discussion with the Director of Patient Care (DPC), I found out that the management team of the hospital organized the RCU after going to other hospitals with similar units; specifically focusing on the physical set up of the unit, staffing patterns, and policies and procedures. The management team consists of two members of the interdisciplinary team, who are the DPC and the physiotherapist (PT) of the hospital. While working alongside another similar unit, the management team created a model of care for the RCU that included staffing patterns and criteria for admission of patients. The LHIN's provided funding for

equipment and wages for the initial staffing of the RCU. The management team had a clear vision of who they wanted to hire and the type of RCU they wanted to create, which emerged from their own education and after visiting the other units. During discussions with the management team of the hospital, I learned that they wanted the team leader to have excellent knowledge in the goals of restorative care along with excellent nursing and organizational skills and the PSWs needed to have an understanding and passion for the importance of restorative care. Resnick (2012) suggests that nurses or URWs who have the willingness and ability to initiate and support a RCU program are essential for implementation of a restorative care program, which has more recently been called "function-focused care" (p. 15). The decision to staff the RCU with PSWs caused a shift in nursing roles and relationships within the hospital environment, because PSWs had not been working in the hospital prior to the opening of the RCU.

The RCU is staffed with 1 full-time RPN leader and 5 PSWs who provide patient care. Traditionally, hospitals are staffed with RNs and RPNs in Ontario; however, in the past 10 years, the staff mix model has changed with the introduction of unregulated workers (URWs) who provide care to patients (McGillis-Hall, 1998). URWs include health care aides, PSWs, nurses' aides, porters and orderlies. During the evening and night shifts, one PSW provides patient care with either an RPN or RN supervising. PSWs were hired for the opening of the RCU after being trained in restorative care. PSWs are new members of the nursing team. This study will describe the relationship between the nursing team members and the impact on leadership within the context of the RCU's culture.

Research Question and Purpose

This Master of Science in Nursing thesis will address the following research question: How do nursing team (RPN, PSWs and RNs) relationships impact leadership and the culture on one RCU? The purpose of this qualitative research study is to describe how nursing team (PSWs, RPN, and RNs) relationships impact leadership and the culture on an RCU.

The literature review is described in the next section, where I will review the current gerontological literature on nursing teams, leadership, and relationships and RCUs. I will provide a summary of what is known and where the knowledge gaps exist. This review of the literature will further support the need for this qualitative research study of the nursing teams' experiences on the new RCU in an Ontario hospital.

Chapter 2

Review of Literature

As I began reviewing the literature, I discovered that very little research exists on RCUs and nursing practice in RCUs. The literature review included searching the following OVID databases: MEDLINE, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Psych INFO, and PubMED. I also searched the Cochrane Library for any systematic reviews, and two were retrieved. The initial searches were for articles from 2000 to 2013. I searched the following terms: personal support workers (PSWs), health care aides (HCAs) and unregulated care workers (URWs) linked to nursing homes, residential care, acute geriatric care units, acute care for elder units, rehabilitation, restorative care, restorative care unit (RCU), acute care, staff mix models, and hospital. In addition, the following terms relating to staffing: registered nurse (RN), registered practical nurse (RPN), physiotherapist (PT) along with leadership/supervision, were searched. During the search, I reviewed the abstracts. After reading the abstracts of the articles, I decided to keep the articles with the following inclusion criteria: nursing home, LTC facilities, acute care, hospitals, PSWs' work environment (i.e., relationships and communication) because the literature could provide insight into RCU environments. The articles that were not kept after I read the abstracts were home care and community articles because the RCU involves a structured setting with multiple team members who work together simultaneously. I included a total of 19 articles regardless of quantitative and qualitative methodology. In addition, I strived to include articles with a gerontology focus; where the information was not available, I used similar settings to a gerontological unit. For example, I reviewed studies about Acute Care for Elders (ACE) units in acute care settings. The ACE units' model of care focuses on the geriatric population with a rehabilitation focus. In addition, there is an interdisciplinary team involved in

the care of the geriatric patients. Therefore, the ACE unit provides contextual information that could apply to RCUs.

Culture is multi-layered and contextual in relation to work environments. Culture is defined as a holistic flexible and non-constant system with continuous interrelated factors (i.e., knowledge, attitudes, beliefs, values and knowledge) and social relationships, that are influenced by significant historical events and processes (Whitehead, 2005). The following review of the literature will provide insight into what is known about nursing team environments and the factors that influence the culture of nursing units.

In having reviewed the literature extensively, I became aware that most of the research on the PSW role has been limited to LTC. Thus, a gap in literature exists with regards to PSWs experiences in acute care environments. PSWs are caring for patients/residents with increased acuity and complexity in LTC and shorter stays in acute care (HPRAC, 2005). I have included four articles (Berta et al., 2003; Daly & Szebehely, 2011; Kleinman & Saccomano, 2006; McGilton & Boscart, 2007) that provide perspective on the changing roles for PSWs in LTC and in hospitals.

PSWs work in different healthcare institutions where specific aspects of care are primarily performed by nurses (RNs and RPNs). RNs and RPNs are expected to teach and supervise PSWs in addition to delegating care activities; although, nurses do not often feel comfortable or qualified to do this effectively (Kleinman & Saccomano, 2006, p. 166). PSWs can receive instruction in performing specific activities; they are permitted to perform these tasks with direct supervision but these skills are not transferable to other clients (CNO, 2013). PSWs need to be seen as part of the team, yet some employers do not agree because PSWs perform delegated tasks (HPRAC, 2005). Alongside the nurses, PSWs play a supportive role in providing

care, treatments and assistance to patients/residents, which contribute the culture of their work environments.

The role expectations for PSWs are evolving in LTC. Daly and Szebehely (2012) performed a comparative study that reviewed the everyday life of LTC workers in Canada and Sweden. Daly and Szebehely (2012) found that in Canada LTC workers were struggling to meet the demands of their jobs due to increased workload and time constraints, and they report lack a of time for performing tasks and being with residents (p. 143). However, in Sweden the LTC workers were less task focused and more relational (Daly & Szebehely, 2012). According to McGilton and Boscart (2007) family members valued the personalized attention that their loved one received from the PSWs (p. 2152). Not only do PSWs care for the residents, they also need to know each resident's plan of care and adapt to the residents' changing needs. PSWs have had to learn and adapt to the new resident assessments, which has included improving, and in some cases gaining, computer skills. The PSW role is expanding and role expectations are increasing.

PSWs are not prepared for their increase in role expectation including the increased complexity of care and changes in Ontario's healthcare delivery. In Ontario, less than 6% of PSWs work in hospitals, where the majority works in LTC (HPRAC, 2006). Therefore, the PSWs, are expected to care for patients/residents who have complex care needs (medically and personal assistance) (HPRAC, 2006). Berta et al. (2013) performed a qualitative study that examined the evolving role of the PSWs in LTC and community/home care sectors in Ontario. The results of the study indicated that the role expectations for PSWs are expanding with increased demands of competencies and abilities, and increasing their knowledge base to include critical thinking and decision making in order to provide evidence-based immediate responses to care (Berta et al., 2013). In addition, PSWs have had to endure the increased pressures,

expectations, and accountability from LTC organizations and health care system changes (Berta et al., 2013). Berta et al., (2013) also found that not only is the PSW role demanding, but the role is rapidly changing. This coupled with the varying degrees of formal training and varying levels of preparation presents a challenge in work environments (Berta et al., 2013). Therefore, the PSW role is changing due to the demands of the changing healthcare environment.

These constant changes and increased demands are leaving many PSWs overwhelmed and emotionally and physically exhausted (Daly & Szebehely, 2011). Lack of time and increased role expectations have influenced the relationships among PSWs, residents, families, nurses, and managers, which also has impacted the culture within care settings. RNs and RPNs, who work with PSWs, have experienced role conflict and increased expectations in their roles.

The relationships between team members are an important factor, which are based on education and roles. Role expectations for both RPNs and PSWs are demanding. I have included five articles on supervisory roles amongst nursing team members in LTC and hospitals (Kleinman & Saccomano, 2006; McGillis-Hall, 2003; McGillis-Hall, Doran, & Pink, 2004; McGilton, Hall, Wodhis, & Petroz, 2007; McGilton, McGillis-Hall, Pringle, O'Brien-Pallas & Krejci, 2004). Supervisor support is important in creating a collaborative work environment. McGilton et al. (2007) studied the interrelationships of supervisory support, job-related stress and job satisfaction amongst nurses' aides in Ontario nursing homes and found that nurses' aides reported that perceived supervisory support ranged from moderate to moderately high; conversely, lack of supervisory support were linked to increased job stress (p. 370). McGilton et al. (2007) defined job satisfaction by assessing five areas: personal, workload, coworker relationships, continuing training opportunities and available professional support using the Nursing Job Satisfaction Scale (p. 369). Job satisfaction is influenced at every level of hierarchy

in a LTC facility (McGilton et al., 2007). McGilton et al. (2004) found that RNs and RPNs are put in supervisory roles without the necessary skills to be a leader in LTC settings. Both RNs and RPNs are in supervisory roles in LTC facilities and their ability and capacity to support staff via empathy, reliability, and relationship building was a predictor of job satisfaction among PSWs (McGilton et al., 2007).

In hospital settings, PSWs work in a variety of units: complex continuing care, adult medical, surgical, obstetrical and rehabilitation (McGillis-Hall, Doran, & Pink, 2004; HPARC, 2006, p. 7). RNs and/or RPNs supervise the PSWs who work in these areas. Two studies reviewed staff mix models (RN/RPN and URW) in Ontario hospitals and found that higher numbers of RNs/RPNs resulted in better patient outcomes (e.g. urinary tract infections, wound infections and patient falls), and RNs reported higher job satisfaction when both RPNs and URWs worked on their units (McGillis-Hall, 2003; McGillis-Hall, Doran & Pink, 2004). There are numerous staff mix models that exist; however, more importantly, roles and role expectations should be clearly defined in order to enhance relationships between team members.

The relationship amongst the interdisciplinary team members is also an important factor that influences culture. Relationships in gerontological nursing refer to the connection, association or involvement between nursing team members and their supervisors in LTC and hospital settings. Relationships can influence culture both positively and negatively. In reviewing the literature, I have included three articles that provide insight into the relationships between nursing staff and their supervisors in LTC settings (Casper & O'Rourke, 2008; DeForge, vanWyk, Hall & Salmoni, 2011; McGilton et al., 2008). Supportive relationships provide the feeling of being valued, whereas negative relationships can leave team members feeling unappreciated. The relationships between staff and their supervisors in healthcare settings

can be described as complex PSWs want to feel appreciated and needed, and they would like managers to understand the PSWs' role and the value that they bring to patient care. Casper and O'Rourke (2008) examined the relationship between empowerment structures and provision of care in LTC facilities and found that the quality of care improved with access to structural empowerment (i.e., information, support, resources, and formal and informal power). Yet, PSWs felt that they were not able to meaningfully contribute to the quality and type of care residents received (Casper & 0'Rourke, 2008). When analyzing quality of relationships in LTC, Casper and O'Rourke (2008) also found that 44.5% of health care aides are not asked for their opinions and are rarely asked about management issues (p. S263).

PSWs offer valuable insight into the care they provide each resident. However, their feedback is rarely heard or requested in LTC (McGilton et al., 2008). McGilton et al. (2008) performed a grounded theory study in LTC and discovered that PSWs' frustration resulted from not having the authority to make decisions and their lack of input regarding residents' care. In addition, PSWs reported that having the support of immediate supervisors (for example, RNs) can help resolve conflicts or issues in a timely manner, which assists in building positive relationships with residents and families (McGilton et al., 2008, p.139)

PSWs must follow many rules and regulations from both the perspective of the organization and those outlined by the MOHLTC. The hierarchy of leadership within the organization further impedes relationship building because of the limitations of the PSW role (McGilton et al., 2008). In a critical ethnographic study, DeForge, vanWyk, Hall and Salmoni (2011) found that an atmosphere of surveillance and a "culture of compliance" for senior leaders, nurses and PSWs existed in LTC facilities (DeForge et al., 2011, p. 424). DeForge et al., (2011) also reported that PSWs were afraid to care for the residents because, if something went wrong,

the blame eventually would move down the hierarchical structure until it fell upon them (p. 424). The culture of compliance and disconnect becomes elevated when there is a difference in the number of years that PSWs and managers have worked in a LTC facility (DeForge et al., 2011,p. 424). The culture of a LTC facility is directly related to rules, increased workload, feelings of being watched, and the shift of blame onto frontline workers, such as the PSWs (DeForge et al., 2011). PSWs reported that supervisors did not respect them on a consistent basis (Casper & O'Rourke, 2008, p. S263). As illustrated, supervisory support is required for PSWs to feel needed and supported in their roles given the demands of the LTC environment. Although, supervisory support is needed, being part of the team is also very important.

The feeling of being part of the team directly influences culture through a persons' behaviour and their ability to participate in decision-making. In addition, being part of the team is influenced by a person's values, but also influences how each person behaves, reacts and feels. PSWs want to be considered valuable members of an interdisciplinary team, which includes PSWs, RPNs, RNs, doctors, occupational therapists (OT), PT, dietary staff, housekeeping staff, and program staff (Deforge et al., 2011). A better understanding is needed about how PSWs can be more fully integrated as part of the interdisciplinary team and be perceived and treated as a valuable team member (DeForge et al., 2011). Therefore, PSWs or other team members who do not feel supported and valued, and who have feelings of frustration in a new environment creates opportunities that can lead to conflict between team members.

I found two articles that provided different perspectives of conflict in nursing work environments (Almost, 2006; McGillis-Hall, 2003). Conflict can be the result of role conflicts with relation to working with different nursing staff (RNs, PSWs, and RPNs). For example, conflict amongst team members can be the result of ineffective staff mix models. In a

comparative-correlational study in eight Toronto hospitals, McGillis-Hall (2003) found that RNs experienced high levels of role conflict regardless of staff mix models with PSWs; however, it was unclear if this was directly related to working with PSWs or the changing role of the RN. Although, the study did not focus on the geriatric population, the study results provide insight into the relationships between RNs, RPNs and PSWs on hospital units.

In an effort to understand the context of conflict amongst nursing team members, Almost (2006) describes conflict as multi-dimensional with both positive and negative effects, and that conflict occurs when there is the perception of opposition between two or more people (p. 448). Sources of conflict include individual characteristics (for example, education differences), interpersonal factors (for example, lack of trust), and organizational factors (for example, changes due to restructuring) (Almost, 2006). Conflict impacts leadership in an organization; therefore, it is important to understand the outcomes and sources of conflict that have an effect on the nursing work environment.

Leadership can have a direct influence on a nursing unit's culture through organization structure. I found four articles that provide different views on leadership amongst nursing team members, residents and families in LTC and hospital settings (Boltz, 2012; Downey, Parslow & Smart, 2011; Harvath et al., 2008; Kontos, Miller, & Mitchell, 2010). The hierarchal levels of leadership influence the organization and the working conditions for front-line staff, including staff mix. Leadership plays an important role in developing a culture that bridges the gap between managers/supervisors and PSWs, residents/patients, and families.

Leadership is based on relationships. One study revealed that the PSWs in LTC have their own way of caring for residents that is not captured in the computerized Resident Assessment Instrument – Minimum Data Set (RAI-MDS) documentation system (Kontos,

Miller, & Mitchell, 2010, p. 352). PSWs are part of an interdisciplinary team that consists of other health professionals with different backgrounds who work toward a common goal for a patient. The interdisciplinary team members are not hearing and recognizing PSWs' contributions; yet the PSWs provide the individualized care for each resident and the standardized interventions do not provide adequate information for quality care (Kontos, Miller, & Mitchell, 2010, p. 352). PSWs report that they know the residents' idiosyncrasies. Increasing the leadership skills of nurses who work with front-line staff can improve the quality of care and the work environment (Harvath et al., 2008). More research is needed on how leadership can assist in building relationships and defining the importance of the PSW role in an interdisciplinary team.

Part of nursing leadership is the role of informal leaders in healthcare organizations, which are often part of the interdisciplinary team. Downey, Parslow and Smart (2011) describe the characteristics of informal leaders, who are nurses that work in acute care settings. After speaking with nurse managers in two large hospitals, Downey, Parslow and Smart (2011) found that informal leaders can be easily identified, they know their roles, they impact the unit and they are able to shape their organization (p. 520). Leadership provides support by prioritizing care and supporting clinical policies and practices (Boltz, 2012, p. 34). Therefore, informal leaders can impact culture positively, if they are supported by their managers, acknowledged, and used as assets on nursing units (Downey, Parslow and Smart, 2011).

The majority of PSWs' work environment is in long-term care; thus, a gap exists with regards to literature on RCUs when I searched the key terms: restorative care units. Therefore, I explored other types of geriatric units to provide me with a baseline of information that would provide insight into an RCU. I found a systematic review and meta-analysis on Acute Care for

Elders (ACE) units. I discovered that ACE units are focused on geriatric patients who have had an acute episode, such as an injury or illness, and the goal is to prevent complications and functional decline (Fox et al., 2012). In a systematic review and meta-analysis, Fox et al. (2012) found that ACE units included the following criteria:

> patient-focused care; interdisciplinary team members who are nurses and doctors along with physiotherapists, occupational therapists and social workers; frequent meetings for medical reviews with the interdisciplinary team to plan care for patients; early discharge planning; prepared environments; usual nursing care refers to standard nursing care and medical care without a functional focus; and nurses provided care on specified (medical, medical-surgical or surgical orthopedic) units (p. 2239).

In summary, Fox et al. (2012) found that interdisciplinary teams were a "unique characteristic of acute geriatric units" (p. 2243). Thus, the description of the ACE units' characteristics provided insight into the context of a similar unit. The culture of a unit is multi-layered and has many contextual factors that can guide or constrain the attitudes and behaviour of team members.

The culture of an RCU involves reviewing the context (ideas, experiences and meanings) and patterns/themes that are identifiable when data (participant and observation) are collected over time (Powers, 1996, p. 194). According to Sapir (1924) culture refers to "general attitudes, views of life and specific manifestations of civilization that give a particular group of people its distinctive place in the world" and Wolf (2007) adds that culture also looks at way of life of a group and the learned behaviour that is created and transmitted among its members (as cited in Munhall, 2007, p. 295). Henderson (1996) performed a descriptive ethnographic study on the culture of care in nursing homes. Henderson (1996) revealed that caregiving is based on tasks and time, which is derived from a traditional medical/hospital model where the physical needs

prevail over the psychosocial needs. The psychosocial needs of each resident require more time and staff. Henderson (1996) discussed how the front-line worker/resident/LTC environment produced a forced daily interaction. Henderson (1996) found that residents and front-line workers interacted in a nurturing and caring pattern that led to the front-line workers having an in-depth knowledge of the residents' behavior and care needs.

The culture of a nursing unit can either constrain or guide the behaviours of team members through social expectations about appropriate behaviours and attitudes. Staff mix models and role expectations are affecting the work environment of LTC facility, and leadership, relationships, and teamwork are all factors that influence the culture of an RCU. There is a described need for attaining connections and maintaining relationships within a LTC facility, where PSWs want to feel that they are part of the interdisciplinary team. Leadership can be viewed as a concept that is characterized by a set of skills and attributes associated with the ability to affect change at all levels within an organization (McBride et al., 2006). Leadership helps to empower and improve the work environment through building the relationships with staff, treating staff members individually, inspiring and motivating staff. PSWs value the relationships between their co-workers, patients/residents, and families. The differences in values result in conflict, which also influences the culture of an environment. Teamwork helps to build collaboration, develop cohesion between staff, decrease staff turnover, and improve staff satisfaction/job satisfaction (Deforge et al., 2011; Harvath et al., 2008; Kontos, Miller, & Mitchell, 2010; McGilton et al., 2008).

After an extensive review of the literature, the key factors that mostly impact culture were: changing roles, supportive relationships, teamwork, leadership, and conflict. I found that there is limited research on nursing team leadership in RCUs and how relationships influence the

culture of these units. Much of the current literature is limited to LTC. The words, actions, and patterns of members of a group are key components in understanding the culture of institutionalized care settings, LTC facilities, and hospitals. More literature in regards to how the nursing team relationships impact leadership and culture within any RCU is needed. This study will describe the relationship between the nursing team members and the impact on leadership within the context of the unit's culture. This focused ethnographic study will explore this topic further.

Chapter 3

Methodology

Theoretical Perspective

In reflecting on the literature, I chose the Critical Social Theory (CST) with the focus on intersectionality as the theoretical perspective I wanted to use. CST is based on the principle that certain groups or people in society are marginalized or oppressed (Sumner & Danielson, 2007). CST helps explore and question the social contexts within the RCU to provide insight into what is happening in practice at the organizational level (Sumner & Danielson, 2007). In addition, historical, economic, political, and organizational factors create a power hierarchy, which can influence the roles, relationships, and culture in the RCU (Sumner & Danielson, 2007). CST focuses on power within social relationships and its influence on social structure and power distribution (Sumner & Danielson, 2007). Power is lived out through the actions of staff, patients, and families. CST addresses the power relationships between the RNs, RPN Leader and the PSWs, as well as between PSWs and patients/families. Power influences the lives, relationships, and experiences of individuals and groups (Sumner & Danielson, 2007). I will use the CST perspective as a means to question the power in social relationships, uncovering who holds the power, and who is oppressed by power (Sumner & Danielson, 2007). The added understanding provides insight into how power contributes to change. However, uncovering sources of power was not the primary focus of the study.

Intersectionality is a feminist sociological theory with a long history. In the late 1980s, Kimberle Crenshaw (1993) coined the term “intersectionality” (as cited in Hankivsky et al., 2010, p. 2). According to Hankivsky et al. (2010), intersectionality focuses on the differences in groups and examines the differences in multiple social factors within the groups.

Intersectionality will guide the exploration of the day to day experiences of the nursing team in the RCU and aids in the understanding of the experiences of the nursing team as a group. This understanding will provide insight into the social positions and power relations in the RCU. Intersectionality is an interlocking framework that addresses gender and power relations from a structural and individual perspective (Hankivsky & Christoffersen, 2008).

Intersectionality is based on three key assumptions in regards to social relations, categorization, and power. The first assumption is that social life cannot be placed in discrete strands, which provides insight into the multi-dimensionality of the relationships within the RCU. In addition, the categories of social identities are not prioritized (Hankivsky et al, 2010). Thus, I did not assume that the social relationships in the RCU are the same and that each member shares the same experience. Intersectionality assists in examining their relationships by uncovering the convergence of their experiences at the intersecting axes of oppression. The intersecting axis reveals how oppression (i.e. gender, race, class) and how power is experienced, maintained, reproduced and lived out in relationships on the RCU. The second assumption attempts to understand "what is created at the experiences of what is being created" and not to simply add categories (for example, race, gender, sexuality and class) to one another (Hankivsky et al., 2010, p. 3). The intersecting axes of oppression are not predetermined in regards to hierarchy and importance (Hankivsky & Christoffersen, 2008). A hierarchy of social identities does not exist in intersectionality because no one category is more important than another (Hankivsky et al., 2010). The third assumption critically examines the social constructs of social inequality. Uncovering the power structures provides information about social relationships and how power exists in the RCU. Uncovering the macro- and micro-relational perspectives of the RCU provides the intersectional framework when analyzing the inequality of social construction

and power dynamics, rather than a one-dimensional approach (Hankivsky & Christoffersen, 2008). For example, the process of uncovering the norms and constraints that inhibit equal communication and participation in a work environment reveals the communication patterns and how staff develops symbolic meanings, which are all components of the RCU culture. Policies and practices interact with the power structures and those who have the ability to make political decisions that influence social structures. Staff and patients follow the normalized day-to-day existing routines of the RCU; thus, the CST and intersectionality framework help to uncover these norms and tease out the layers of oppression (Sumner, 2004). The social locations of gender, race, class, relationship, roles, and education uncover how these social locations shape the normalization of "what is" in the RCU. This study will unveil the layers of context and uncover what is being created at the intersection of the participants' social locations and experiences on the RCU.

According to the literature, contextual factors, such as historical contexts, nursing roles, education, work experiences and relationships are factors that influence the nursing work environment and the intersectionality framework informs me to look at what factors intersect (Hankivsky & Christoffersen, 2008). Pre-existing hierarchies are situated within the nursing profession based on education and roles. For example, RNs require a degree, RPNs require a college diploma, and PSWs require a college certificate. From an intersectional perspective, hierarchies do not exist and power relations are not predetermined (Hankivsky & Christoffersen, 2008). Thus, the intersectionality framework guides me to uncover the convergence of nursing team lived experiences, and to understand what is being created and experienced at each intersection. The intersectionality framework assists me to understand the layers of context that either facilitates or hinders, that either enables or constrains the lived experiences of the nursing

team working in the RCU. In addition, the intersectionality provides a framework to uncover the cultural differences and to unveil the accepted norms and practices on the RCU. A focused ethnographic approach will provide the methodology for studying the culture of the RCU.

Focused Ethnography

Ethnography provides a holistic perspective of the culture. The ontology for ethnographic studies is subjective, where members of a cultural group will have many interpretations of a lived reality (Creswell, 2007, p. 17). The ontology of ethnography is subjective, interpretative, and influenced by its environment.

A focused ethnography, which is a branch of ethnography, is a term used for smaller ethnographic studies that have a focus on a specific issue or problem, are in a particular setting, have a limited number of participants, and is time-limited (Knoblauch, 2005; Streubert & Carpenter, 2011). A focused ethnography shares the same beliefs and assumptions of ethnographies that I have applied to this study. Ethnographers believe that culture contains symbols and patterns that are derived from the members' subjective view of reality (Creswell, 2007, p.17-19). This relativistic view provides insight into group members' culture where knowledge is viewed as having many truths and reality exists within the context of that culture, which includes multiple views of reality (Munhall, 2007, p. 103). Culture involves people in a group who interact with each other over a period of time (Creswell, 2007, p. 68). Culture includes the way people walk, talk, act, dress, sleep, and their habits and attitudes; it also includes the contextual layers that facilitate or constrain and enable or hinder the behaviours of the group members (see Appendix A for important features of ethnographic studies).

My research study is a focused ethnography because it has a focused issue (meaning of the team relationships impacting leadership and culture), specified setting (RCU), limited

number of participants (staff who work in the RCU) and is time-specific (period of one month) (Knoblauch, 2005; Savage, 2000). In addition, the focused ethnography allowed me to gain insight into the team members' shared experiences, how their experiences were structured and allowed me to understand the interrelationship between the interdisciplinary team members' relationships, leadership and their environment – the RCU (Cruz & Higgenbottom , 2013).

An assumption of ethnography is that every group of humans develops a culture that guides its members' views, meanings, values and experiences, which includes symbols, patterns and knowledge (Hammersley & Atkinson, 2007; Wolf, 2007). Ethnographers believe that members of a group interact so frequently that they develop shared patterns of behaviour, beliefs, language, and knowledge (Hammersley & Atkinson, 2007; Creswell, 2007, p. 68). Thus, an ethnographic approach that is focused on the RCU is appropriate for my study because it provides me a way of collecting data (observation, interviews, writing field notes), and principles that guide the analysis of data (methodology) and an interpretation of the RCU culture (Savage, 2006). Therefore, an ethnographic approach provides a way to explore the day to day experiences of the RCU by being part of the natural setting, asking team members to share their stories through interviews and to observe the day to day behaviours of the nursing team members.

Emic and Etic Views

Ethnography uses both the emic and etic views of a group's culture (Hammersley & Atkinson, 2007; Wolf, 2007). Epistemologically, I explored and attempted to learn as much as I could about the realities of the nursing team by spending time with them in order to gain an "insider view" or emic perspective (Creswell, 2008, p. 17). The insider view of a group's culture refers to looking at the language and concepts or means of expression amongst group members.

The etic perspective refers to the "outsider view", which looks at the researchers' interpretation of the culture. In this ethnography, I identified myself as having both an insider and outsider view of components of the RCU. I had knowledge of nursing roles and interdisciplinary teams because of my previous work experiences as a health care aide, RPN and RN; however, I did not have an insider view of this RCU. I did hold an outsider view because I worked in different environments (LTC and hospitals) but I did not work on an RCU. Previously, I worked with two of the nursing team members in other hospitals, so I knew who they were and how they worked with others. However, in order to not let my previous experiences define my approach to what I would see and hear on the RCU, I wrote down my personal thoughts and feelings of being their colleague to make clear my own ideas in a reflexive journal. Setting the ideas aside enabled me to be constantly aware of what I believed and I kept it separate from what the participants shared with me. This cognitive process is also referred to as bracketing (Streubert & Carpenter, 2011). Therefore, I identified myself as a colleague and I put aside any preconceived ideas of leadership practices of the nurses that I had worked with.

As the researcher, I reflected that I needed to remain professional with a focus on collecting information by asking questions and observing, and by wearing my student name tag as a reminder to staff that I am in a different role. However, I still considered myself as an outsider because I had not worked with them on the RCU. Therefore, as an outsider, I am able to interpret the culture of the RCU and to understand the knowledge that is indirectly shared with me through the sharing of the team members' stories.

These perspectives provided me with thick descriptions (Geertz, 1973) or contextual-rich descriptions of meaningful information that gave insight into the actions of the members within the context of the RCU. The interpretation of the data uses an inductive approach. An inductive

approach enabled me to draw data from observing the group members in the RCU and then I looked for repeated behaviours. As a result, I had the ability to interpret the meaning and intent of their actions and behaviours in conjunction with individual interviews (Geertz, 1973). I asked group members questions to learn about what is happening in the RCU through interviews and I also focused on the group members' behaviours and actions on the RCU.

Ethical Considerations

A submission of my research proposal was made to the York University Research Ethics Board (REB) for review in July 2013. The REB provided ethical approval in July 2013. I then approached the hospital for ethical approval. As the first step in that process, I met with their leadership team. When I presented my study to the Chief Executive Officer (CEO) for approval, we had a lengthy discussion about power and confidentiality. In addition, the CEO posed questions and concerns, which I responded to before my study could take place in the organization.

After consulting with my thesis supervisor, I changed my research question and I added the sentence "uncovering sources of power is not the primary focus of the study". I presented these changes to the hospital's Ethics Committee, which they approved (see Appendix B for hospital ethics approval). The hospital's Ethics Committee provided ethical approval to the do the research at the hospital in October 2013. I sent an amendment to the York University REB notifying them of the changes to my proposal and they approved the amendments in November 2013 (see Appendix C for REB ethics approval).

Informed Consent

Prior to data collection, I provided the participants with the informed consent forms for their review before I obtained their written consent for participating in the study (see Appendix

D for the consent form). Participants were told the purpose of the study and I answered any questions they had during the interview or observations. During my times of observation, if anyone on the RCU did not wish to participate in my study, I would have stepped away from that interaction, and I would not ask questions or collect data (field notes).

Privacy and Confidentiality

The interviews took place in private offices, or in empty patient rooms on the RCU where I ensured privacy for the participants by closing the door. In the findings section, I did not include any identifying information (including role) of RNs, management or allied health professionals in order to protect the anonymity of all participants of my study. The RCU is small and there are some roles with only one person in that role, so confidentiality had to be protected. I did identify the role of PSW and RPNs in the findings section because I interviewed more than one, so anonymity can be maintained. All data collected are confidential. All hard copy data, such as field notes, are kept in a confidential filing cabinet at York University. Digitally collected audio files were saved on a password-protected laptop and erased after transcription occurred. Participants were informed about how data would remain secure. Data will be kept for a period of five years following my study and then destroyed.

Risks and Benefits

There are risks and benefits in all research studies. Participants enjoyed talking about the leadership practices on the RCU and they gained an understanding of the role they play in the RCU and their influence on leadership on the RCU. The potential risks in my study were minimal because it involved interviews and participant observation. Participants were not exposed to any risks beyond what they would normally experience in their daily lives. I tried to

ensure participants were comfortable during the interview. Participants were informed that they could withdraw from study at any time without any consequences to them.

Setting

The research took place in a small rural community with a population of 2,000 people in Ontario, Canada, where I was the primary researcher. The hospital had a 10-bed RCU together with a 10-bed in-patient acute care unit. I chose the hospital because it has recently opened a RCU that employs and trains PSWs with an RPN Leader during the day shift and both RNs/RPN supervision of the PSWs during the evening and night shifts. I did look at other RCUs; however, I chose this RCU because of its close proximity to where I live making it convenient. In addition, I had familiarity with the hospital organization and its stakeholders.

Sampling

The sampling strategy was purposeful. In purposeful sampling, participants are selected based on their wealth of knowledge, which provides in-depth insight into the purpose of the study (Creswell, 2007, p. 125). I purposely recruited staff who worked on the RCU because they provided different insights and provided me with rich data into the different interdisciplinary team roles, relationships, leadership, and the day to day experiences and practices of the RCU.

Recruitment Strategy

Participants were recruited from a RCU in southwestern Ontario. Staff (nursing personnel, management, and others) were notified through posters advertising my study and inviting their participation (see Appendix E for the recruitment poster). Before my study began, I went to the hospital and introduced myself during clinical rounds and outlined the purpose, methodology and data collection for my study. I answered any questions staff had and I invited staff to participate in my study. I also met with the Director of Patient Care (DPC) and I asked

her to send emails to all staff who worked on the RCU inviting them to participate in my study. The DPC also put up recruitment posters in the nursing station and on bulletin boards around the hospital.

Participant Selection

I selected staff who worked on the RCU as participants for my study. Participants included RNs, RPNs, PSWs, and others with whom I set up individual interviews, where the participants provided insight and understanding into leadership practices and relationships in the RCU. The information gathered helped me delve into the richness of the relationships, and I explored leadership and the culture-sharing patterns on the RCU. The inclusion criteria included all staff who works on the RCU. The study excluded patients.

A total of 11 interviews were conducted and each participant completed a demographics form (see Appendix F for demographics form). All participants were female; eight of the 11 participants were part of the nursing team (including RNs, RPNs, and PSWs); one was a manager, one was an allied health professional and one was an administrative support person. With the exception of one participant, all participants had worked on the RCU since it opened. With regards to years of experience in the profession, two of 11 participants had 25 plus years; three participants had 21-25 years; one participant had 16-20 years; three participants had 11-15 years; one participant had 6-10 years, and one had less than five years. Therefore, nine out of 11 participants had greater than 11 years of experience. The age of the participants varied with one participant between 21-30 years of age; two participants between 31-40 years of age ; one participant was over 51 years of age and the majority (seven of 11 participants) of those interviewed were between the ages of 41-50 years of age (see Appendix G for participant demographics).

Data Collection

In order to collect the data, I went to the hospital from October 2013 to November 2013. I asked questions, I listened, and I observed group members, and I wrote field notes, which allowed me to get to know the nursing team members roles' and the role of leadership and the contextual factors that facilitate and constrain, enable and hinder the experiences on the RCU. This study employed ethnographic methods of participant observation, formal interviews, repeated observations and written field notes, also known as triangulation. Miles, Huberman, and Saldana (2014) describe triangulation as the support of findings by at least three independent methods (p. 299).

Hammersley and Atkinson (2007) define participant as observer as the researcher who is openly being a part of people's lives for a period of time – watching, listening, asking questions (formally and informally), in order to shed light on the phenomena of interest and to gather knowledge about the nursing team's social world by participating in it (p. 98). Participant as observer and in-depth interviews were used to collect data in October – November 2013. Data saturation refers to the point when information collected no longer adds to the understanding of the phenomena of interest (Creswell, 2007, p. 240). I observed and conversed with participants who most likely possessed explicit or implicit insider knowledge of the social context of the RCU.

I employed the following strategies that assisted with participation in data collection. For observation sessions, I emailed the DPC when I would be at the RCU. I provided participants with the dates and times of interviews, and I rescheduled as necessary to demonstrate that I accommodated the needs of the RCU. I arrived on the RCU ahead of time and I sought consent for 11 interviews and up to four hours of observation from eight participants. I also obtained

informed consent before interviews and before observation (see Appendix B for consent form). This consisted of eight observation sessions amounting to 21.5 hours and 11 interviews until I reached data saturation; during which time I also interviewed participants, observed and took field notes. If a person had explicitly stated they did not wish to be a part of the observations on any particular occasion, I would have stepped away and not collected any data (observation or field notes) during that interaction; however, this did not occur.

I observed the interactions and behaviors of the participants in the RCU. Before my observations began, I sought the permission of 8 participants to shadow them for up to 4 hours, and I obtained informed written consent. All observations and questions asked were directed at the participant. During my observations, I recorded descriptive field notes to record interpersonal interactions, for example conversations/language, non-verbal body language that will be seen; personal feelings, experiences and thoughts were also included. I observed conversations between the RPN Leader with and amongst PSWs during clinical rounds on Thursdays, shift reports (0730hrs, 1530hrs and 1930hrs) and when the nursing team shared information. For example, during clinical rounds, the conversations amongst participants included patient care, ongoing patient health-related issues, care planning and discharge planning. During observations, I recorded how participants responded to each other, how PSWs responded to the delegation of tasks, and how staff interacted during their day-to-day routines. Although I did observe some interactions with patients in the common areas, I did not record information, and I did not enter patients' rooms or write down any identifying patient information in any of my observation field notes.

I collected the data using a semi-structured interview guide (see Appendix H for the interview guide). The semi-structured interview guide questions were created with consultation

with my thesis supervisor. The questions were also derived from the theoretical frameworks. Overall, CST provided guidance in formulating these questions in regards to leadership, teamwork, and relationships experienced in the RCU. The CST guided all the questions to assist in probing into the complexity of the work environment including understanding the conditions of inequalities, constructs of social relationships and providing insight into what is happening at the organizational level. In addition, intersectionality guided questions 4 and 5, which helps to uncover the layers of the social relationships between team members, and to look at the experiences of what is being created on the RCU. After two interviews, I had a discussion with my thesis supervisor to add question number 7 in order to seek further information and to help uncover the convergence of categories (for example, education, relationships, experience) that influence everyday situations. All participants were interviewed once. The semi-structured interviews were conducted in offices or empty patients' rooms of the participants' choice, and the interviews were digitally recorded. Interviews were negotiated with the participants that took place during their work day. I intentionally sought the perspectives of the PSWs (day, evening, and night shifts), RPN Leader, nursing team members, and other staff.

During data collection, I wrote notes to collect all participant observation data. I asked all participants to complete a demographics form indicating their age, gender, length of time in RCU, position in RCU, and the number of years of experience in their profession (see Appendix F for demographics form). I digitally recorded the interviews. I listened to and transcribed all of the interviews using a transcription notation system (see Appendix I for transcription notation system). I have 148 pages of transcribed typed data that took me approximately 24 hours to transcribe. While I transcribed the interviews, I did not include the names of all people and any

personal identifying information. I analyzed the interview and observation data during the data collection process to allow for the exploration of particular recurrent themes.

Data Analysis

CST is a lens that provided a means to analyze study participants' thoughts and actions of empowerment and how the contextual factors facilitate and constrain, enable and hinder the relationships among the staff members. CST and intersectional perspectives provided a basis for questioning the contexts of leadership and social relationships and to acknowledge the contextual layers of social inequality in the RCU. Data analysis began concurrently with data collection. I looked for patterns to emerge when analysis began. The guideline for systematic analysis is based on the work of Miles, Huberman, and Saldana (2014). The process of data analysis is summarized in a table (see Appendix J for process of data analysis). I used the computer assisted qualitative data analysis software (CAQDAS) program QSR NVivo® as a method of coding that uses participants' own words or short phrases and records them as codes (Miles, Huberman, & Saldana, 2014, p. 74). QSR NVivo® provided a method to manage and analyze the data. I used QSR Nvivo® to manually code each transcribed interview and the method helped to categorize words and phrases used repeatedly. The codes were then categorized and themes emerged. Data analysis also consisted of constant comparison of the data collected to identify categories, themes or patterns within and across participants, as well as a comparison of new data to data previously analyzed. To substantiate the categories and the emergence of themes, excerpts from the interviews and field notes are provided. CST assisted in understanding these relationships and their correlation to the background and the current social context within the hospital and RCU (Sumner & Danielson, 2007).

Rigor

Klopper (2008) outlined the importance of establishing rigor throughout a qualitative research proposal. The strategies that I employed to establish trustworthiness of the findings that is an evaluation of rigor were credibility, transferability, dependability and confirmability (Lincoln & Guba, 1985). The first strategy is credibility.

Credibility

Credibility refers to the whether the researcher has established trust and confidence in the truth of the study findings (Lincoln & Guba, 1985). In my study, I established credibility through the data collection process (formal interviews, repeated observations and written field notes) provided me with multiple sources of data, also known as triangulation, which provided converging conclusions (Miles, Huberman, & Saldana, 2014, p. 299). I collected data until I began to hear the same things repeatedly and this indicated that I reached data saturation. Data saturation refers to collecting data until I no longer found new information about leadership in the RCU. The methods of data collection also enabled me to provide thick descriptions of meaningful information, which I displayed in my study findings (Geertz, 1973). The findings are clearly described with a theoretical underpinning. I have also included limitations of my study. All of these strategies helped to establish the credibility of my study.

Transferability

The second strategy of transferability refers to the ability to generalize and apply the findings of the study to larger populations and other contexts (Lincoln & Guba, 1985). In my study, transferability is established through the detailed description of the sample, setting, and processes to allow for comparisons with other samples (Miles, Huberman, & Saldana, 2014, p. 314). Transferability is established through the detailed display of thick descriptions of the

information, which provide the reader with the ability to transfer the findings of the study to other settings based on similar characteristics (Geertz, 1973). My study findings are described and connected to CST and intersectionality. In addition, I have critically examined the sample and the generalizability to other settings and contexts in the limitations section.

Dependability

The third strategy is dependability, which refers to how consistent the findings are and how easily my study can be replicated (Lincoln & Guba, 1985). I have provided the reader with a detailed account of my role and status. The theoretical perspective (CST and intersectionality) is linked and is appropriate to use with focused ethnography. I collected the data in appropriate settings, times and participants, and the findings of my study demonstrate meaningfulness across data sources (participants, contexts and times) (Miles, Huberman, & Saldana, 2014, p. 312). This will provide a reader with the means to conduct the same study in their setting with confidence that the steps that I followed can be transferred into their setting.

Confirmability

The final strategy of confirmability refers to quality of the results in regards to the degree of objectivity (Lincoln & Guba, 1985). I have described the sequential steps in the methods and procedures of the study in detail in order to display confirmability and auditability (Miles, Huberman, & Saldana, 2014, p. 311). I used multiple methods (formal interviews and observation) as a method to confirm the data and QSR Nvivo® to analyze the data into themes and categories. The data analysis verified the consistency of the data. All decisions regarding processes of data collection and analysis have been documented in this study. In the findings section, I displayed the data through using the participants' own voice through the use of quotes and in the discussion section; the themes were the interpretation of multiple interviews and

observations. Throughout data collection, analysis and writing up of my study, I kept a reflexive journal to show that I was self-aware of my own assumptions, values and bias, and I wrote field notes in book, as a form of validation. This reflexive practice is an important component of ethnographic studies and an intersectional framework.

Reflexivity

Reflexivity is an important tool in ethnographic studies because it serves as a reminder that the researcher becomes part of the social context. Finlay (2002) defines reflexivity as "thoughtful, conscious self-awareness" (p. 532). I used reflexive practices as a tool to increase self-awareness and to monitor interactions between myself and the participants in the study. Reflexivity also assisted me in examining the contextual factors that constrained the relationships between me and the participants (Finlay, 2002). I also maintained a reflexive journal in order to record my thoughts to explore my own values about my role in the RCU. As part of reflexivity, I consciously identified that my current role as a Director of Care in a LTC facility has an impact on my role as a graduate student and as a novice researcher. I understood my own role as an influential one regarding hiring of PSWs; however, in the research setting, I was a learner and I maintained that focus throughout data collection. Therefore, reflexivity allowed me to be aware of my own personal characteristics, previous work experiences, age, gender, and education, which may have influenced the relationships with the participants.

I worked with my thesis committee members to continuously evaluate my own learning and my role as a novice researcher. After two interviews, I held debriefing telephones calls with my thesis supervisor in order to modify the interview guide. I transcribed all the interviews and then I sent them to my thesis supervisor for her review, so that all themes and categories could be checked for resonance with my descriptions and discussions. In addition, the findings of my

study were derived from the participants and not from my perspectives or other perspectives, biases, or interests (Lincoln & Guba, 1985).

Dissemination of Research Findings

The findings of the study will be shared with the organization as per the request and permission from the CEO of the hospital. I will disseminate the findings with key stakeholders: the CEO, Chief Nursing Officer and DPC. I have shared my plan of dissemination with staff of the RCU at the initial recruitment presentation of my study. I will share the findings of my study with the RCU staff after I successfully defend my thesis at the end of May 2014. I also plan to submit the findings for publication to the Canadian Journal of Nursing Research in order to share the knowledge to other organizations and nurses.

Limitations

The study limitations are in the following areas: methodology, sampling and data collection methods. The subjective nature of focused ethnographies and the interpretive skills of the researcher could question the trustworthiness of the findings (Cruz & Higginbottom, 2013). I worked with my thesis committee members to assist me with building my interpretative skills of the data that I collected through discussion, reflection, and practice.

Focused ethnographies can be critiqued for producing one account of reality and one snapshot in time, which could potentially reduce its credibility (Miles, Huberman, & Saldana, 2014). I conducted 11 interviews and collected 21.5 hours of observations over a six week period, which provided me with a variety of differing perspectives of the RCU.

The purposeful sampling was appropriate for the focused ethnography; however, the all-female sample may not be transferable to other healthcare settings, because it does not illustrate heterogeneity with regards to gender. Although, emails were sent, and I asked nursing members,

I did not interview all key informants such as the DPC and physicians which could have limited transferability.

The data collection included the use of an audio recording device, which may have affected the nursing team members' free expression of thoughts and feelings compounded with my own inexperience as a researcher. For example, during one interview, one PSW focused on the recording device, which caused her not to speak freely. In addition, my presence on the RCU could have created social behaviour in others that would not have normally occurred, which could have influenced data collection and analysis (Miles, Huberman, & Saldana, 2014). My role as a Director of Care at a LTC facility influenced the work environment where staff joked that I tried to recruit PSWs; however, I resolved this assumption through reiterating my current role as a graduate student and novice researcher and dispelling their preconceived notions about my role on the RCU. My personal values, beliefs, and attitudes also may have influenced my fieldwork. I used a reflexive journal to increase my self-awareness and to gain insight into my personal responses to situations that occurred (Finlay, 2002). During data analysis, I had to be aware of my own emotions and experiences while the participants told their stories. Thus, I needed to block out my own response to their stories, so I could clearly hear the participants' voices. However, I had to be aware of my own silences, when I could not hear their stories. Therefore, I would ask myself, what are the participants' trying to tell me?

Chapter 4

Themes

There are four themes regarding the RCU's culture that have emerged from the inductive analysis of interview transcripts, observations, and field notes. The themes are (1) uncertainty of within in a new intersection; (2) working together emerges from within; (3) leading within a hierarchy; and (4) everyone contributing within a team. The themes are presented and explained individually and, for the theme of leading within the hierarchy, categories are included and indicated in italicized text. The categories are explanatory descriptions that I will further identify and elaborate in a theme (Miles, Huberman, & Saldana, 2014, p. 86). The themes provide insight into the factors that impacted the RCU culture the past two years.

1. Uncertainty within a New Intersection

Uncertainty within a new intersection refers to how the acute care and RCU intersected to create new experiences in an unfamiliar environment that created uncertainty but fostered acceptance of the RCU. The hospital changed 10 of its acute care beds into RCU beds, which caused a sudden change in the acute care environment. As a result, the culture of the acute care environment also underwent a change. The intersection of the RCU and acute care unit created a new working environment where new people came together to work within a co-existing unit. One PSW described the RCU/acute care unit environment as still unfolding, where uncertainty is also uncovered:

> Only, you know, we are only just over 2 years into this right, so it has been, we are at the toddler stage. The birth of the baby has happened boom and we're still figuring out, we are still laying out some stuff and we are coming up with some interesting ideas too. (I-16)

In one interview, another PSW described the uncertainty of the work environment and how the new relationships impacted the RCU where team members initially met resistance:

> There was a few speed bumps, a couple of hurdles to overcome but like I said, I think that once that trust was built on that foundation, I mean it's with any new relationship, right, you don't just dive in and be like everything is fine la la la. We really didn't have a honeymoon phase. I think that, like now, is more so our honeymoon phase. It's kind of backwards. It's kind of like, walls built up. I don't really know how this is going to work, but now it's great. (I-18)

Another RPN described the uniqueness of the new environment based on historical context and work experience:

> They both complement each other. It's certainly does us good to see both sides of the coin about what works for one and what works for the other and whether or not, you know, they, they fit together. It is a very unique situation in having both on the same, basically the same unit. So, yeah, I do think they work really well together. I think they offset each other, um, and it's good for us to be able to see. Cause a lot of us; you know when it was acute care strictly, that's all we were used to. Yes, it's a different mindset, a little bit more laid back in restorative care I find, and that's good. (I-12)

The introduction of new roles and new relationships created a culture where the nurses took on the responsibility to adapt in an uncertain work environment. In addition, the behaviours of the team members revealed that uncertainty has influenced the social constructs and behaviours of the RCU.

2. Working Together Emerges from Within

Working together emerges from within refers to how nursing team members are individually motivated to foster social relationships and a shared vision. The nursing team members shared their vision of the RCU program and how the RCU program has intersected with their own personal beliefs and attitudes, societal values and expectations of the importance of older persons wanting to age at home. In one interview, a PSW discussed how she felt working in the RCU, "It's a great feeling working here, love working here; love that they [patients] get to go home" (I-4). Two participants described the importance of having team members that understand the program and how this intersected with their own personal beliefs and values:

> Like everybody that they have hired has a really positive attitude in terms of having the patients strengthen and become independent as they can so they can go home. Staff seem to all have that attitude from what I see and it works well. (I-20)

> Actually it's kind of interesting to see some people when they come in the door and then when they go to leave. What the big change is and a lot of it is attitude. I think a big part of that is the RCU is having that attitude that, you know, we are going to help you get better here. But we can only help you so much. You have to do the rest of it, and being positive helps. (I-16)

One PSW described the work context:

> I am very happy that the program is here and not just because I work here. I just think that it's great. I believe in it. I do. It's hard work, perseverance, some days are not easy. (I-22)

Another RPN added, "I think it really does bring something into the community. It helps sustain the hospital, yeah; I don't know where it [the hospital] would be without it [RCU}." (I-14)

The nursing team described the theme of working together emerges from within as being a unique program that is part of a larger societal context. The RCU adds value to society where patients are able to age in place and provides the hospital with a unique program that fills the gap between a traditional hospital and home. Therefore, the beliefs and values of each team member have influenced the attitudes and behaviours amongst team members, which is indicative of the culture of the RCU.

3. Leading within a Hierarchy

A hierarchy can be defined as "a system in which people or things are placed in a series of levels with different importance or status" (Mirriam-Webster, 2014). Hierarchy can be furthered described as the positions of authority in the RCU. This includes from highest position to lowest in regards to levels of education and positions in the RCU: DPC, RNs, RPNs, and PSWs. Leading within a hierarchy refers to the ability of team members to lead within the predetermined roles in the RCU. The RCU has established routines and practices that have

unveiled leadership that exists within a hierarchy, and this is also demonstrated in decision-making, managing conflict, and how the nursing team works together. One participant described leadership as the following in the RCU:

> So it's kind of nice that it is not top down. It's very central. I mean there have been times where the PSWs as well have an issue that they bring up and that is perfect. I don't feel like it's, like I said, top down. (I-20)

And an RPN described leadership as the following:

> Same thing, actually you know, we all kind of stand in that pyramid. You know, RNs, RPNs, you know kind of down the list. I don't see them like that. To me they are just like me working here as well. (I-2)

Teamwork. Leadership is also demonstrated in the RCU through the ability to work together as a team. Teamwork is defined as the ability for team members to work together to achieve a task or a goal. Teamwork not only involves knowing the hierarchical relationships within the RCU but how it lives within the RCU through communication, decision-making and conflict management practices. One participant described teamwork as:

> It's ongoing because there can be issues, even at night, on what's happening. So, that's always an ongoing conversation we have amongst all of us. And there is no view that is looked down on. The PSWs have just a great of voice as the RPNs do as the RNs do. I think the idea has to be full circle. Right, so there is a lot of discussion, even at report, to about what's going on and what's the plan for people, what are we looking at? (I-16)

> The team approach is, I think, is very muchly alive within it, because people are trying to work together to make an atmosphere patient-oriented to what their needs are, and I think following down from your RN, to your physio, to your RPN, to you name it, to the PSWs. (I-16)

Decision Making. Decision making in the RCU can be described as the process of performing an action on the basis of making a decision based on knowledge, patient care, and previous experience. In an interview, participants were asked to describe their role in decision making on the RCU. The hierarchy exists within knowing one's role and scope of practice in the RCU; thus, this PSW practiced her role within these guidelines:

> My way of thinking, I work within my scope of practice, what I was taught in school. I don't do anything outside; I don't do anything that's delegated unless I am shown properly and I'm told and I feel that it's comfortable and what I'm supposed to do. That is what we were totally always taught to do. (I-22)

One RPN described her comfort of having the hierarchy of leadership within the RCU, which facilitated her ability to problem-solve:

> Quite a bit being a nurse, but again, like I said before, I enjoy having that superior person that if I feel that, ok, this is what I would do, then I have somebody to consult with it. Do you think this is the best course of action? Do you think this is appropriate kind of thing? So, I mean, we do a lot of the decision-making but we also have another brain to kind of help us with that as well (I-2)

Managing Conflict. Managing of conflict is seen through the social interactions of the nursing team members. Managing conflict is the process of two or more team members where there are differing views and usually opposing views (Almost, 2006, p. 444). However, sources of conflict can also be viewed as individual characteristics (value differences, differences in demographics), interpersonal factors (lack of trust, injustice or disrespect, poor communication), and organizational factors (interdependence and changes due to restructuring) (Almost, 2006). One RPN discussed the acknowledgement of the hierarchy; however, the participant did not follow the hierarchy when managing conflict:

> If there is staff issues a lot of the staff will come to me if it can't be resolved between whoever the staff is. I just send them to <DPC>[1] because I am not in the position to play one against the other or that's not my position at all. We try to diffuse the situation if we can, if not, talk to <DPC>. She's the boss. (I-14)

Another RPN discussed how team members resolved conflict between team members rather than following the hierarchy of how conflict should be managed:

> So, actually, <DPC> had called a meeting and we were all going to go in and talk about it and then…she didn't want <DPC> involved. So, we did. We worked the weekend

[1] DPC = Name of Director of Patient Care

> together. We did physio. We had a discussion and I said this weekend has gone very well and she said yes I'm surprised. I said well this is the way it can always be. (I-14)

Another participant shared their view on how conflict is related to organizational factors in the RCU. This RPN reflected on how issues are often band aided; she states, "when there is an issue, they turn to us and look to solve the problem then. Maybe we could help prevent the problem" (I-14). In another interview, one PSW shared her personal strategy for managing conflict as she stated, "you know, you just kind of keep cool and nope you don't have respond to everything that is coming at you; you just kind of turn a deaf ear and smile, and nod" (I- 4). The nursing team discussed managing conflict through acknowledging the hierarchy, but chose to find their own paths in managing conflict with each other. Therefore, leadership practices encompass the RCU culture by creating opportunities for autonomous nursing practices including the nursing team's ability to work as a team, how they participate in decision-making, and how they resolve conflict amongst each other.

4. Everyone Contributing within a Team

The theme, everyone contributing within a team, refers to the nursing team's ability to learn and to share knowledge with everyone (DPC, RNs, RPNs, PSWs, occupational therapist (OT), physiotherapist [PT] doctors, and patients). More specifically, PSWs contribute something new to the RCU. The RCU environment has differing layers of knowledge amongst the nursing team members. The varied levels of education (RN, RPN, PSW), experience, and positions, creates an environment where teaching/learning relationships inevitably emerge and new experiences are created. The addition of PSWs to the hospital work environment has added a different layer of knowledge to the nursing team, which has changed the culture of the acute care environment. One participant described the new experiences for PSWs in the RCU:

> …have given them a lot of responsibility, and which they didn't have in a lot of their other jobs. And with that comes really good things; they become more creative, they bring ideas, they do not have any fear about presenting questions or comments or concerns for us all to work through. So that is great. We have been lucky enough that they are very keen and so not only do they help once they have done their own things in the morning like <PSW> is covering this afternoon, um, we actually, instead of having a physio assistant cover when <physio assistant> is not here, ... a PSW will cover for her. We are one of the very few, I'm sure anywhere, that continue rehab on the weekends because the PSWs have all been trained. (I-6)

During the interviews, PSWs discussed their ways of learning through their own desire to expand their knowledge in their new environment:

> There is always room for PSWs to expand their skills and I try to look for things outside of work that keep those skills up and keep them refreshed. Like I'm always asking the nurses little lingo: "What is that?" "What is that acronym mean?" "What procedure?" So you know I am always learning so when I hear the lingo I can know. (I–22)

One RPN talked about a discussion she had with another PSW regarding the importance of education:

> One [PSW] stated that she'd really like to take a medication course. And I said, I would not discourage you from that at all because even then you know what the meds are for and like when we are talking about and you know what they are for… You know, I said, absolutely go. You know the more stuff you can take the better. (I-14)

In addition, the nursing team members rely on each other in order to improve their clinical skills and rely on each other's clinical expertise. One RPN added:

> And the doctors here are the first ones to say they don't know about wound care. So whatever we decide, I always go to the two girls that have the training to assist me with what I need because they have the knowledge (I-14).

Thus, the RCU environment is where nursing team members all have something to contribute and the PSWs add a new layer of knowledge and value, which adds to the culture of the RCU.

The themes and categories that I have described have illustrated that the hospital environment underwent a change with the introduction of the RCU. Through the interviews, observation, and field notes, the study uncovered that there is a caring and empathetic perspective that is shared and valued by the nursing team members. The themes of: uncertainty

within a new intersection; working together emerges from within; leading within a hierarchy; and everyone contributing within a team provides a cultural perspective of the nursing teams' lived experiences on the RCU. The findings have provided insight into how the culture has changed over the past two years by working through the uncertainty of a new working environment, creating a new set of values and beliefs that impacts the behaviours on the RCU, participating in leadership practices through decision making and managing conflict, and uncovering that PSWs are a contributing member of the nursing team. Thus, the culture of the RCU is multi-layered and contextual with a new set of expectations that guide the behaviours of the RCU nursing team members.

Chapter 5

Discussion

The purpose of this focused ethnography was to describe how nursing team relationships impacted leadership and culture of care in the RCU. The participants in the study described their experiences of working on the RCU. The findings also revealed themes and categories that have provided me with an understanding of what is created and experienced and thus, provided insight into the culture of the RCU.

Uncertainty within a New Intersection

Uncertainty within a new intersection refers to how the acute care and RCU intersected to create new experiences in an unfamiliar environment that created uncertainty but fostered acceptance of the RCU. There are multiple, simultaneous and interactive factors of the new environment that influenced the nursing team members experiences the past few years (Hankivsky & Christoffersen, 2008). The contextual factors included an unfamiliar work environments, new relationships, nursing team members with no experience in RCUs or acute care, varying levels of experiences and education, changing roles for the nurses who worked in acute care and the overarching feeling of not knowing how the RCU was going to work. In the interviews, PSWs described how they were still figuring things out, hitting some bumps, but managing the hurdles along the way. Evidently relations were not predetermined, which created experiences of uncertainty, but also opportunities for new insights, new experiences and facilitated growth for the team members of the RCU.

The roles within the RCU have evolved with the inclusion of added education because new roles were developed. Initially, the introduction of the RCU within the acute care environment caused friction regarding the new roles, but also the uncertainty of how it would change the hospital work environment. Vaismordi, Salsali and Ahmadi (2011) described the

nurses experiences of uncertainty in medical and surgical wards of a teaching hospital. Similarly,Vaismoradi, et al.(2011) found that the uncertainty of a hospital work environment caused feelings of fear, anger, agitation and frustration based on unclear practice expectations. Although, there were feelings of uncertainty in my study, the hospital environment has evolved with the acceptance of the RCU within the acute care environment and the acceptance of the PSW role.

In a study with a similar purpose where the authors described the changing culture of a new unit in a small community hospital, Moffit and Butler (2009) looked at the effectiveness of nursing initiatives to improve patient outcomes (e.g. pressure ulcers and falls) and patient/nurse/physician satisfaction during the merging of a medical unit and oncology unit. Moffit and Butler (2009) found that the medical unit's culture underwent a change where nurses felt that they were empowered to make changes and where nursing staff became part of the solutions. Moffit and Butler (2009) also found that the unit functioned through coordination and collaboration along with willingness to implement changes for improving quality care. In my study, I also found that the nursing team members continued to coordinate and collaborate. The participants described this process as finding new ways of doing things, coming up with new ideas and working together.

Working Together Emerges from Within

The theme of working together emerges from within refers to how different aspects of each team member, theoretically speaking, intersect together to create a new status whereby nursing team members foster social relationships and developed a strong belief in the RCU program. There are multiple and contextual factors that intersect, and it is at this intersection that a completely new status is formed (Hankivsky & Christoffersen, 2008). The new status of the

RCU is the understanding that the nursing team has a vested interest in the success of the RCU. The contextual factors that intersect together include the understanding of nursing team roles, sustainability of the hospital and the importance of social relationships. The interviews revealed that the nursing team members recognize that the RCU is important to the community and to the sustainability of the hospital. Nursing team members acknowledged that the hospital is small and, with the growing number of cut backs to healthcare, they feared that their hospital may close. Therefore, it is imperative to understand what is experienced when these contextual factors intersect. Thus, nursing team members experience a shared commitment to the success of the RCU program that intersects with their own personal values, beliefs, and knowledge.

The nursing team members understood their roles, their personal values and beliefs in working together for the shared goal of patients to age in place. During the interviews, the nursing team members shared their love for the RCU program, and how they shared a positive attitude that motivates their need to help the patients to return home. The interactions between the nursing team members and patients, and their own lived personal experiences, age, ability, gender and education, all intersected in a simultaneous, interactive way with patient care in the RCU. In reviewing the demographics five of the PSWs had previous job experiences in LTC, where their patients (residents) were not able to go home, and the RPN Leader brought years of experience in acute care. A generational gap also existed; however, there is always an exception to the rule. One PSW aged 31-40, shared her story where she bridged the generation gap when she began watching Coronation Street on television (TV), which is one of the oldest running soap operas on TV, in order to build a relationship with one of her elderly patients. The PSW valued what was important to her patient, and she understood that by giving them something to talk about provided the distraction for the patient while she did her restorative care exercises.

These shared values, beliefs, and goals are a reflection of the importance of fostering relationships, which creates a positive culture of the RCU. Together, these experiences have intersected to give the nursing team members a sense of influence over the patients' recovery and for their patients to return home. It is the convergence of these experiences that have led to a confidence and a passion for the success of the RCU program.

Social relations were not predetermined in the RCU. What has resulted is that the RCU team members' relationships also extended beyond the hospital environment into friendships. The uncovering of these experiences revealed a level of bonding that exists, where working together converged with the dynamic play of social, political, and cultural contexts (Van Herk, Smith & Andrew, 2011). Padgett (2013) also described the relationships between team members as collegial (Padgett, 2013). Collegiality refers to the relationship of how team members work together and how professional standards are maintained (Hansen, 1995). The shared goal of working together has strengthened nursing team relationships. In addition, this shared goal of working together has demonstrated leadership within the RCU, which has impacted the culture of the RCU. There is a dependency on each other for support, which is visible in the RCU through their day to day actions with patients and each other in their commitment for the patients to return home. The culture of the RCU includes a positive spirit of co-operation and mutual assistance between team members that is highly valued (Padgett, 2013). The nursing team members have collaborated, assisted, and cooperated with each other for the well-being of their patients. This is consistent with a study by Padgett (2013) that stated that maintaining positive relationships has practical advantages and mutual dependency provides nurses (PSWs and RNs) with a strategy where nurses were given a lot of leeway to make decisions about care practices (p. 1407). The nursing team members valued each other's autonomy in their own roles as RPNs

and PSWs who can make decisions regarding patient care on the RCU. The ability to make decisions is based on their roles as RPNs and PSWs, and their personal and professional experiences.

It is the simultaneity of multiple, interactive effects (i.e. gender, age, race, sexuality, ability, education, personality) and the convergence of all the experiences that influenced staff attitudes and values, which provided insight into what it means to work together in the RCU in order for the patient to return home (Hankivsky & Christoffersen, 2008). The study provided new insight into the nursing-team experiences of belonging to a program that supports the societal values and expectations of having seniors aging in place, addressing the needs in the community, and caring for our aging population. The collegial relationships have held team members accountable to each other and their standards of practice, which is not consistently found in nursing practice (Almost, 2006). Similar to my study, Tornabeni and Miller (2008) found that nurses with different backgrounds have created a collaborative work environment and a greater commitment to goals, supportive relationships, coordinated and collaborated efforts amongst the nursing team have enabled leadership practices to develop, which has influenced the culture of the RCU.

Leading within a Hierarchy

Leadership is viewed as a hierarchy within the RCU. There are multiple and intersecting influences of policies and practices on the RCU, which are integrated with the historical context and the nature of power structures that exist on the RCU (Hankivsky & Christoffersen, 2008). A predetermined hierarchy existed in the RCU in relation to roles and positions when it existed as a 20-bed acute care unit. CST is based on the principle that hierarchies exist and that people in society are oppressed (Sumner & Danielson, 2007). The interviews that were part of my study

reveal that a hierarchy is visible as staff discusses chain of command. The term chain of command originated in the late 1800s in the military to describe the executive order of positions (Mirriam-Webster, 2003). Understanding the impact of leadership helps determine if the relationships in and among PSWs are effective and if they acknowledge the hierarchy and power and its influences in clinical practice (Sumner & Danielson, 2007). The nursing team uses the term "chain of command" to refer to the hierarchy of positions (DPC, RN, RPN and then PSWs) in the RCU; however, in a positive manner. The nursing team views the hierarchy as a way of providing guidelines for their positions and to assist in defining their roles. However, McGilton et al. (2008) discussed that a hierarchy can be viewed as a way of impeding relationships relating to the limitations in roles. The hierarchy is acknowledged by the team members, however, as a positive factor and not a suppressive factor as the words "chain of command" infers. There is also a strong sense of teamwork where decisions are made as a team through open communication, and relying on a variety of roles within the RCU based on education (RN, RPN, and PSW), and years of experience in their professions. A systematic review and meta-analysis found that interdisciplinary teamwork was a unique characteristic to an acute geriatric unit, and these study findings were similar and supportive of the value of teamwork (Fox et al., 2012, p. 2243). The acknowledgement of knowing the layers of the hierarchical structures serve as guiding principles within the context of the RCU.

The nursing team described a hierarchy that was in existence relating to positions within the RCU with relation to managing conflict. As previously discussed, the nursing team referred to the hierarchy in a positive manner relating to procedures and guidance as they coped with issues of conflict. Therefore, there was a layering of contextual factors when it involved managing conflict due to structural procedures, individual practices, and social identity.

Managing conflict is inevitable in work environments based on differences in goals, needs, desires, responsibilities, perceptions and ideas (Almost, 2006). The introduction of the RCU into the acute care unit created some initial conflict in relation to the changes in goals and responsibilities of working with new team members. Personal experiences with conflict, historical procedures and practices in the hospital, the nursing team members' role, education, age and gender are social factors that influence the context of conflict management (Almost, 2006, p. 448). Nursing team conflict occurred in relation to changes in the acute care environment, but also working with team members with varying levels of education and the introduction of PSWs into the hospital. Conflict occurred due to differing personal values and conflict management resulted from creating supportive relationships amongst each other; regardless of gender.

Women predominately make up the nursing profession and PSWs in Canada, and this is also evident in the RCU with only one male PSW (Marchildon, 2005). Holt and DeVore (2005) performed a meta-analysis that indicated that gender had an influence on conflict management styles, where females used a more compromising style as compared to males (p. 179). Similarly, in my study, I uncovered that the females did use a more compromising style; however both male and females were aware of the hierarchy of roles /supervision if the conflict could not be resolved. I unveiled the misunderstandings between nursing team members related to communication failures. The nursing team members acknowledged the hierarchy of how to resolve conflict as part of the hospitals policies and procedures. However, the nursing team created its own internal process to resolve issues. The nursing team shared that they have specific strategies to assist with managing conflict with their team members before initiating

assistance from team members in a higher position. Some nursing team members felt comfortable going to other team members for advice or trying to collaborate in solving issues.

The role that each nursing team member plays also has an influence on how to manage conflict and reduce breakdowns in communication, which will help build team relationships and build capacity for equal treatment, regardless of status, education, role and age. Communication challenges in the RCU result from assumptions and cultural misunderstandings between team members, but also highlight how conflict is normally managed in the RCU. Each nursing team member contributes to the culture through how conflict is managed, and how each of their roles impacts the culture of the RCU.

Everyone Contributing within a Team

Everyone contributing within a team refers to all nursing team members having the ability to learn and to share knowledge with each other, especially the PSWs. The social relationships between team members are multi-dimensional, with no prioritization of social categories (for example, education, experience and role) (Hankivsky et al, 2010). The experiences of the nursing team member evolved from how they saw themselves, how they were seen by others, and how they related with each other.

The nursing team members realized that they need each other; and each team member has something to contribute within the team. The nursing team acknowledges that roles, knowledge and expertise do not take priority over another. The introduction of PSWs into the hospital two years ago created a change in roles for the existing staff and new roles for new staff. The PSWs who were hired did not have the experience of working in a hospital setting or in an RCU; however, they had the experience of working with the geriatric population in LTC settings. Therefore, PSWs relied on formal education, their own years of experience, and the nursing

expertise of the RPN Leader. The RPN Leader is viewed as an expert based on many years of experience and intuitiveness, and the PSWs are viewed as experts in the personal care for patients because of their work experience with an average of 11-15 years in their professions. The RPN Leader also shares her expertise and guides the PSWs based on her education, age, and her ability, which intersects through her own personal lived experiences of being an RPN. The PSWs also sought ways to share their knowledge and improve their knowledge within the RCU. The PSWs also relied on the nurses' expertise for previous practices and procedures in acute care but also developed new ones for the RCU. The diversity of the team members provided an opportunity where power relations existed; however, these factors did not constrain the needs of the RCU. The uncovering of the differing layers of knowledge and varied experiences has created new learning opportunities amongst team members. For example, PSWs were trained to do restorative care exercises on the weekend, which is unique to this RCU. Therefore, the RCU is a nursing unit where experiences converged to facilitate learning, enabled personal growth and fostered supportive relationships amongst the nursing team members.

PSW roles are evolving in team-based delivery of care. Berta et al. (2013) suggests that PSW are not seen as knowledgeable workers in complex care environments. In my study, the findings go against the norm for PSWs who are seen as equal members in the RCU and who play an important role in the RCU. In fact, the findings indicate that PSWs are the informal leaders of the RCU. Informal leaders are individuals who do not have a formal authority title, yet they advocate for their workplace, and heighten the contributions of others as well as their own through influence, knowledge, relationship-building, and expertise (Smart, 2010). Downey, Parslow and Smart (2011) studied nurses in acute care and found that nurses in acute care who have characteristics of informal leaders as "being humble, always willing to help, they do not

blow their own horn – trying to take credit and focus on getting their jobs done" (p. 519). In my study, these same characteristics of informal leaders that Downey et al. (2011) have described are shared by the PSWs who work on the RCU.

The PSWs have built strong relationships within the RCU, and they have become effective communicators in the interdisciplinary team. PSWs have influenced the culture of the RCU through their openness and sharing their knowledge and expertise of patient care, being enthusiastic about the program, being team focused, and genuinely caring approach towards staff and patients (Downey, Parslow & Smart, 2011). Thus, PSWs have effectively become part of the interdisciplinary team and have influence the culture of the acute care environment through their informal leadership qualities.

Implications for Nursing Practice, Policy and Research

The findings add to the body of research that reviews where PSWs are working in acute care settings, where RPNs are in supervisory roles and how team relationships impact the culture of work environments. In addition, the nursing team plays a unique role in healthcare and this study helps to offer a better understanding and appreciation of the nursing profession and its role in society (Cruz & Higginbottom, 2013). The RCU plays an important role in the transition from hospital and the ability for patients to age at home.

Practice

The implications for nursing practice based on the findings of this study are that PSWs are an integral part of the nursing team. PSWs can effectively contribute their ideas and share their knowledge about their patients and how to care for older adults with the nursing team members. Therefore, PSWs can play a significant leadership role in RCUs and other healthcare settings if they are provided with mentoring and on-going support from their supervisors (i.e.

team leads, managers). In this study, PSWs have shown their informal leadership skills and this can be fostered in other RCUs.

The implications for education include that the PSWs scope of practice and educational needs are changing. For example, during the interviews PSWs spoke of wanting more knowledge of medications and to further understand nursing language; however, they are clear in their requests that they do not wish to be RPNs. Instead they would like more baseline knowledge in order to assist the way they care for patients each day. Continuing educational opportunities can include leadership skills, chronic disease management, mental health, medication management, team work, critical thinking and decision making which are all well within the current PSW scope of practice (Berta et al., 2013; HPRAC, 2006). Thus, supervisors can support their staff through seeking and offering continuous educational opportunities (CNO, 2009). This learning would further develop the PSW in his or her role promoting satisfaction with their work life.

The study provides an example of how a RCU can be implemented in a pre-existing acute care unit. Employers can use this study to implement an RCU in their organization. The results may be of interest to other RCUs, who may recognize some of their own reality in the results, thus increasing the credibility of the study. In addition, the study also uncovers the tacit skills, decision rules, and routines of the RCU, which provides new information for policies and procedures (Savage, 2006).

Another practice implication of this study is about the RCU itself. My findings indicate that the RCU is valued in both the hospital organization and the overall community. Other organizations can factor these findings into planning or setting up an RCU with regards to the size of the unit, staffing patterns, educational needs, staff requirements, and how relationships are developed and structured which are detailed in this research thesis.

Policy

The implications for policy from my findings include that it informs policy makers that there is value of having rural RCU programs in hospital settings. The MOHLTC (2012) could use these findings to fund more RCU programs in rural areas because this type of program aligns with Ontario's Aging at Home Strategy where the purpose is to have older persons age at home. Advocating for more RCUs in rural areas is highly needed; thus, nurses can attend public meetings, write letters to lobby decision makers for continued funding of RCUs and work with the media to bring attention to need for RCUs in smaller rural communities. In addition, nurses can work with organizations, such as the Registered Nurses Association of Ontario (RNAO), and join their efforts in advocating for care for senior population. The RNAO supports where healthcare system must evolve to meet the changing needs of the aging population (2014). As part of the knowledge transfer of my study, I will prepare a short brief of my study findings to the MOHLTC hoping to disseminate my key findings on the benefits of an RCU from the staff perspective. In addition, the MOHLTC can review rural communities and identify the needs of those residents who live in those areas, and create programs to meet these needs. Therefore, MOHLTC could have hospitals be multi-faceted settings for the growing needs of the older adult population.

Research

The implications for research from my findings include that no standardized policies exist specifically for the RCU. However, the nursing team has been very strong in creating roles and routines on the RCU based on existent hospital wide policy and procedures. While these team members are strong, standardized policy would increase role clarity and strengthen their leadership skills. Leadership plays a role in identifying policies and practices of the unit, but

also clear identification of the importance of having a team leader position in place (Boltz, 2012, p. 43; Resnick, 2012, p. 15). Thus, procedures and policies need to be created specifically for this environment. A future research study could address this question on policy.

Another research implication from my study findings include that this focused ethnography is the first of its kind. The RCU is situated in a small rural community hospital, so a recommendation for further research can include that the study be replicated on a larger scale. For example, the study could be replicated on a larger RCU in an urban area, where the sample would include a diversity of different people.

My study also focused on the nursing team leadership and relationships, so future research could include patients and family members in order to provide a different insight of an RCU. Based on the findings, the PSW role could further be explored in relation to informal leadership qualities of PSWs in other acute care environments.

Limited evidence exists with regard to the setting where RCUs are located. Based on my findings, should we be examining where RCUs are located and if RCUs could function better in a different health care environment. Should they be situated as part of a LTC facility?

Chapter 6

Conclusion

The changing needs of healthcare organizations have led to changes within the cultures of healthcare organizations. The RCU is a restorative care program that is a time-specific focused program for patients with a goal to improve their health and functional abilities in order to promote successful transition from hospital to aging in place and to reduce acute hospitals admissions and emergency visits. I uncovered the different contextual layers that facilitate or constrain; and enable or hinder the everyday experiences of nursing team members. I identified the influencing factors of the current culture of the RCU based on social, cultural and historical constructions.

In this focused ethnography, I heard the nursing team members of the RCU describe their culture of working in the hospital with the inclusion of the RCU two years ago. The introduction of PSWs to the hospital environment created a new social environment that resulted in a change of culture. The change in culture created an environment of uncertainty that also facilitated learning of new roles and a new way of doing things. I explored the experiences of the nursing team members in the RCU who's newly constructed reality uncovered two distinct units that fit together within an acute care environment.

The new status of the RCU is the understanding that the nursing team has a vested interest in the success of the RCU. The nursing team believes in the importance of the RCU, its value to the hospital, and how it aligns with the societal views of aging in place. It is at this new intersection where their own social location and the shared goals amongst nursing team members have converged to create a culture that has socially set expectations about appropriate attitudes and behaviors on the RCU. In addition, collegial relationships were formed between team

members, resulting in increased collaborative efforts and coordination amongst the interdisciplinary team. Thus, the creation of collegial relationships revealed leadership practices, and accountability to each other.

In the interviews, I heard the team members' accounts of how hierarchical structures and differences existed; however, the study findings indicate the RCU environment worked within a hierarchy of leadership. Leadership existed within the pre-existing hierarchies and nursing team members had established their own internal pathways for managing conflict and decision-making, which did not follow any particular hierarchy. This study demonstrates that nursing teams have the ability to lead in their day-to-day practices with regards to resolving conflict and making decisions within their team. The convergence of being a part of the acute care environment and pre-existing hierarchies resulted in a changed culture. The culture has provided leadership opportunities for the nursing team to participate in decision-making and managing conflict on the RCU.

My study contributes to a better understanding of the culture in an RCU. The multi-dimensional relationships and interacting factors between team members have created an environment where everyone contributes equally within the team. The priority of one social category over another does not exist and each team member is valued for their role, education and personal experiences. However, with the addition of PSWs in the RCU, the study uncovers that PSWs are the informal leaders with the continued support from their supervisors (RPNs, RNs, managers) and their nursing team. PSWs can effectively lead by contributing their ideas and sharing their in-depth knowledge of patient care needs with the nursing team members. The PSWs also seek opportunities to improve their knowledge and improve their practices. The PSWs influence the culture of the RCU through relationships, their expertise, their genuine

ability to care for patients and staff and their awareness that teamwork is very important. Therefore, the study provides an understanding of the lived experiences of the PSWs where they are valuable and contributing members of the interdisciplinary nursing team.

Focused ethnography using CST helped me explore the social limitations in the relationships and leadership practices of the nursing team members and how this impacted the culture on an RCU. The focused ethnographic approach enabled me to describe and understand the experiences and connections between nursing team members on the RCU. In addition, the CST with the focus of intersectionality helped to uncover the contextual intersecting factors (i.e. historical, social, and political) that influenced the behaviours and social relationships on the RCU. The nursing team members' have created a culture where nursing team members' have a shared belief in the RCU program, and they have demonstrated leadership in their day to day activities by working together, supporting each other, learning together and valuing the relationships with each other. Therefore, this study provides an understanding of the RCU culture by illuminating the complexity of nursing team relationships and leadership practices on the RCU.

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Appendix A

Features of Ethnographic Studies

- Researcher participates, overtly or covertly, in the daily lives of people for an extended period of time – watching what happens, listening to what is being said, and asking questions through formal and informal interviews
- Peoples actions and accounts are studied in every day contexts
- Data is gathered from a wide range of resources including participant observation and/or informal conversations
- Data collection for the most part is relatively unstructured
- Focus is usually on a few cases, generally small-scale and single setting or group of people inorder to facilitate an indepth study
- Analysis of data involves interpretation of meanings, functions and sequences of human actions and institutional practices, and how these are implicated in larger contexts.

Hammersley, & Atkinson. (2007).

Appendix B

Hospital Ethical Approval

J. HAS APPLICATION RECEIVED APPROVAL FROM OTHER HOSPITAL/INSTITUTION RESEARCH COMMITTEES?

X YES o NO

If yes, attach copy of approval and recommendation if any.

All copies of personal health records that were made or received must be destroyed in accordance with the information sharing agreement.

I certify that the information reported here is accurate and that the personal health information will not be used for future projects without prior approval of a research ethics board.

Primary Investigator — Date: August 13, 2013

Division/Department Head Signature of Approval — Date: Aug 22/2013

In making this request, I acknowledge that failure to comply with the terms and conditions of the information sharing agreement is cause for termination of the agreement and, where, applicable, a complaint to the Information and Privacy Commissioner/Ontario.

Date: August 13, 2013 — Signature of Requestor

Attach:

- X Completed Proposal
- X Copy of Informed Consent
- □ Privacy Agreement where available N/A
- □ Copy of Case Report Form N/A
- X Letter of Approval if study reviewed by a Hospital, University or Institutional Ethics review Board Committee. **Note letter of approval from External Ethics Review Board is mandatory for [redacted].**

Approved By:

CEO — Date: Oct 1, 2013

Chair of Ethics Committee — Date: Oct 1, 2013

YORK
UNIVERSITÉ
UNIVERSITY

Appendix C
York Ethical Approval

Certificate #: STU 2013 - 118

Amendment Approved: 11/04/13

Memo

OFFICE OF RESEARCH ETHICS (ORE)

5th Floor,
Kaneff Tower,
4700 Keele St.
Toronto ON
Canada M3J 1P3
Tel 416 736 5914
Fax 416 650 8197

To: Lucy Elliot, Department of Nursing, lucyrn@yorku.ca

From: Alison M. Collins-Mrakas, Sr. Manager and Policy Advisor, Research Ethics
(on behalf of Duff Waring, Chair, Human Participants Review Committee)

Date: **Monday November 4th, 2013**

Re: Ethics Approval

Restorative Care Unit: A Focused Ethnography of RPN Leadership in a 20-Bed Hospital

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With respect to your research project entitled, *"*Restorative Care Unit: A Focused Ethnography of RPN Leadership in a 20-Bed Hospital*"*, the committee notes that, as there are no substantive changes to either the methodology employed or the risks to participants in and/or any other aspect of the research project, a renewal of approval re the proposed amendments to the above project is granted.

Should you have any questions, please feel free to contact me at: 416-736-5914 or via email at: acollins@yorku.ca.

Yours sincerely,

Alison M. Collins-Mrakas M.Sc., LLM
Sr. Manager and Policy Advisor,
Office of Research Ethics

Appendix D

Informed Consent

Study Name: *Restorative Care Unit: A Focused Ethnography on Leadership in a 20 bed Hospital*

Researcher (PI): Lucy Elliott, **Email:** **Phone:**

Information and Informed Consent for Research Participants

Dear Research Participant,
As a graduate nursing student, I am conducting a research study in your restorative care unit that looks at exploring the leadership and culture on the restorative care unit (RCU).

Purpose of Study: The purpose of this qualitative research study is to describe how nursing team (PSWs, RPN) relationships impact leadership and culture of care on a RCU.

What You will be Asked to Do:
You will be asked to participate in formal interviews where you will be asked questions to speak about your personal experiences with working on the RCU. I may also to shadow you for a period of 4 hours during your work day and ask questions, and record my observations. My questions are very open and general. There are no right or wrong answers because we just want to know what you think and feel to the best of your ability. For instance, I might ask: How would you describe leadership in this restorative care unit, what does leadership look-like? In order to adequately capture everything that is said, I will be using a tape recorder during all sessions. You will always be able to decline and I do not use any names or identifying descriptions of people.

Risks and Discomforts
There are no specific risks or direct benefits for you that I know of ahead of time. I can tell you that some people find it helpful to have the opportunities for sharing ideas and experiences and for having access to information that meet personal needs and preferences. The primary benefits will be to the community of researchers and health professionals who are seeking the understanding of the RPN Leadership role and its impact on the relationships and culture in restorative care unit. I hope the interview will be enjoyable and informative for you. I will not probe and will respect your silence should you chose not to speak about a particular topic.

Withdrawal from the Study
This letter is an invitation to you to participate in the study. You may choose to decline the invitation now, and you may also terminate your participation at any time during the study, for any reason, if you so decide. If you withdraw, there will be no change in your relationships with any of the health professionals involved, or with York University, or any other group associated with this study. If you do withdraw, I will destroy any data I have on you to the greatest extent possible.

Confidentiality
All information you provide during the study will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report or publication of the research. I will be tape recording the interviews and you have the right to have your words removed from the study at any

time. Should you decide to participate; personal information about you will be kept strictly confidential. You will also have access to any written reports or papers that are published about the study, should you wish.

Your words and phrases may be used in written and spoken reports of the research but all identifying information will be removed. That is, your name or other personal information will only be viewed by myself and all identifying information will be kept in a locked cabinet only accessible by myself. All data gathered for this study, including paper record and audiotapes, will be kept in a locked cabinet at York University and only research staff will have access to data. Only researchers will have access to the data and your confidentiality will be provided to the fullest extent possible by law.

Questions about the Research
This study has been reviewed and received ethics clearance by the Human Participants Review ('Ethics') Sub-Committee, York University's Ethics Review Board and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about the research in general or about your role in the study, please feel free to contact Lucy Elliott using the contact information below. If you have any questions about this process, or about your rights as a participant in the study, please contact the Senior Manager & Policy Advisory for the Office of Research Ethics, 5th Floor, York Research Tower, York University (telephone 416-736-5914 or email: lucyrn@yorku.ca).

Legal Rights and Signatures:
I _____ consent to participate in the study *"Restorative Care Unit: A Focused Ethnography on Leadership in a 20 bed Hospital "*conducted by Researcher Lucy Elliott. I have understood the nature of this study and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent to participate.

Signature_____ Date: _____
Participant

Signature _____Date: _____
Principal Investigator/Graduate Student

I further agree to the following:
(Please initial for consent)

Using words from my journal in research/education reports _____

Including descriptions in research/education reports ____

Your participation is important to the success of this study and I look forward to your contribution. Should you have any questions, please let me hear from you.

Yours sincerely,

Signature

Appendix E

Recruitment Poster

School of Nursing, Faculty of Health
York University

PARTICIPANTS NEEDED FOR RESEARCH IN LEADERSHIP, RELATIONSHIPS and CULTURE on the RCU

I am a graduate student doing my master's thesis research project.

I am looking for volunteers to take part in a study that will review how nursing team (PSWs, RPN) relationships impact leadership and the culture of care on a RCU.

As a participant in this study, you would be asked to: participate in an interview and to be observed during your shift.

Your participation would involve 2 sessions that include a ½ -1 hour interview and approximately 3 hour observation period during your time of work.
For more information about this study, or to volunteer for this study, please contact:
Lucy Elliott, RN, BScN

MScN Graduate Student
at
Telephone Number:
Email:

This study has been reviewed by and received ethics clearance through the York University Research Ethics Committee and SBGHC Ethics Committee.

Appendix F

Participant ID:_____

Demographics Form

Please check the correct circle and complete the form.

Age:

- Less than 20
- 21 – 30
- 31 – 40
- 41 – 50
- 51 – 60
- Over 60

Gender:

- Male
- Female

Length of time at RCU:

- Less than 6 months
- 6 months – 1 year
- 1 year – 2 years
- Over 2 years

Position in RCU:

- Management
- RN
- RPN
- PSW
- Other

Number of years of Experience:

- Less than 5 years
- 6 – 10 years
- 11 – 15 years
- 16 – 20 years
- 21 – 25 years
- Over 25 years

Appendix G

Participant Demographics

Participant Random Code	Age	Gender	Length of time at RCU	Position in RCU	# of Years of Experience
i.	31-40	female	1-2yrs	RPN	21-25 years
ii.	41-50	female	1-2yrs	PSW	11-15 years
iii.	41-50	female	over 2 yrs	Management	21-25 years
iv.	41-50	female	over 2 yrs	PSW	11-15 years
v.	21-30	female	6 months – 1 yr	Administrative Support Personnel	less than 5 years
vi.	51-60	female	over 2 yrs	RPN	over 25 years
vii.	41-50	female	over 2 yrs	RPN	over 25 years
viii.	31-40	female	over 2 yrs	RN	16-20 years
ix.	31-40	female	over 2 yrs	PSW	11-15 years
x.	41-50	female	1-2 yrs	Allied Health Professional	21-25 years
xi.	41-50	female	over 2 yrs	PSW	6-10 years

Appendix H

Interview Guide

The following questions were asked to participants on the restorative care unit (RCU):

1. Describe what you consider to be your main role on the RCU?

2. How would you describe leadership on this RCU, what does leadership look-like?
    a. What does leadership look-like? (probe)

3. We talk about team environments; do you see the RCU as a team environment?
    a. Who is on the team (probe)?

4. So many situations happen at work, during your _____ (probe: look at demo form) in the RCU, can you think of a time/situation where you felt that you made a difference with your team members?

5. How would you describe your relationship with others on the nursing team:
    a. RPN Lead?

    b. PSWs?

    c. Others?

6. Describe your involvement in decision-making on the RCU? (probe: patient assignment, scheduling, patient input)

7. I want you to reflect on your time that you have worked on the RCU and I want you to go back and think about either an everyday situation (probe: bowel routine) or a challenging situation (probe: pain that wouldn't go away) about one of your patients. I don't need to know patient information but I want you describe the experience? What helped you to know what you needed to? What did you draw on?
    a. Other people
    b. Past experiences
    c. Education

8. Do you have any further insight into any team relationships or leadership on the RCU that you wish to add?

Appendix I

Transcription Notation System

Meaning	**Symbol**
1. Laughing	(laugh)
2. Removal of identifiable information	<name deleted>
3. Short pause	…
4. Long pause	….. OR …pause…
5. Varied actions (i.e.: higher voice, clapping of hands)	(name of action)

Appendix J

The Process of Data Analysis

Steps	Description
1. Order and organize the collected data	Transcribe digitally recorded interviews and field notes.
2. Read the data repeatedly	Read through all of the data several times in order to obtain a general sense of the information.
3. Search for meaning units and label the meaning units into codes	A meaning is words, sentences or paragraphs.
4. Group codes together to create subcategories, and categories	Examine each code and then combine them to generate broader and more abstract subcategories and then categories. Each of these categories includes several discrete codes.
5. Generate themes	A theme is a thread of a core meaning among meaning units, codes and categories on an interpretive level. Group the categories together to generate the theme.

Granaheim, & Lundman. (2004); Le Compte, & Schensul. (1999); Miles, & Huberman. (1994) (as cited in Chuang & Abbey, 2009).