Quality Improvement (QI) in Healthcare: A Foucauldian Discourse Analysis Examining QI Through the Lens of Advanced Practice Nurses

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Thesis submitted to the University of Ottawa in partial fulfillment of the requirements for the Master of Science degree in Nursing

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QI IN HEALTHCARE: A FOUCAULDIAN DISCOURSE ANALYSIS

Abstract

Quality improvement (QI) in healthcare increasingly guides the activities of healthcare organizations. Heavy attention and resource allocation to QI has had significant impacts on healthcare workers, including nurses. Clinical Nurse Specialists (CNSs) are healthcare professionals with unique backgrounds who can provide a lens to understanding how healthcare QI is shaped and experienced. Using Dean's governmentality analytic framework, historical documents that trace the emergence of QI in healthcare are analyzed alongside transcripts of semi-structured interviews conducted with CNS participants. Results of this analysis reveal that discourses of hierarchy, regulation, and performance shape experiences and understanding of QI in healthcare. Impacts of these discourses are explored, with attention to how QI discourse limits CNS identity, subjugates nursing knowledge in QI spaces, and to how QI definitions of quality fundamentally differ from nursing-centered definitions, resulting in internal conflicts. The need to re-align QI with nursing knowledge and experience is argued.

Keywords: Quality improvement, discourse, nursing, Foucault

Acknowledgements

As I wrap up this challenging, stimulating, and rewarding research, I want to take a moment to sincerely acknowledge the contributions of the individuals who made it possible to reach this marathon-like finish line. First and foremost, I would like to sincerely thank Dr. Kimberly McMillan, my thesis supervisor for all your guidance and support. I came to you at the beginning of my graduate studies, inspired by your publications on change fatigue in nursing, recounting how they so deeply resonated with me in a way I had not yet encountered in nursing literature. You not only welcomed me as a prospective student but met my enthusiasm for this area of study in a way that was energizing and allowed me to creatively engage in research and literature in a way I did not previously know was possible. You enabled me to push my boundaries, get outside of my comfort zone, and grow in a way I would not have thought possible at the beginning of this degree. Your trust in me as I navigated the critical theory that underscores this thesis combined with your ability to teach, lead, redirect, and keep me on track allowed this thesis to come together in the way that it did, and for that I am so thankful.

To Dr. Brandi Vanderspank-Wright and Dr. Amélie Perron, I owe the sincerest of gratitude for serving on my thesis advisory committee. Amélie, your experience and insights to Foucauldian theory and discourse analysis were invaluable as I engaged with and grasped these concepts myself; Brandi, your help in keeping this work grounded and constructively applicable to nursing issues was instrumental.

To the nurses I encountered in the last four years as I completed this degree, both at uOttawa, and in my own personal and professional life, thank you. Thank you for sharing your voices and experiences and inspiring me to dig into the experiences and issues that impact this

profession every day. Thank you for showing me what resiliency and commitment to the profession in the face of ever-emerging challenges looks like.

To my parents, Mary and Dan, who provided unconditional patience and support as I navigated the ups and downs of this degree, thank you. Thank you for pitching in with house work in my home, caring for your fur-grand-babies without question, and spontaneous weeknight dinners with the occasional cocktail – all these small things took weight off in times where the load felt very heavy; these moments of relief made it possible to complete this degree. I am eternally grateful. To my sister Alanna, who walked alongside me in her own Master of Nursing journey as I simultaneously engaged with mine – your own hard work and devotion to education inspired me to continue, and I am ever so grateful for that motivation and could not be prouder of you now that you have graduated.

Finally, to my life partner and best friend, Ameer. This degree equally belongs to you. I am sincere when I say that I could not have completed my studies without you and your sacrifices along the way. Allowing me the quiet time and space to engage with my studies, being a board to bounce ideas off, expressing genuine care for and curiosity towards my work and research, being a shoulder to cry on when I needed to cry, and stepping up in the management of our home and the day-to-day things that are necessary in making this beautiful life we have created go round – all of these things allowed me to complete this marathon and reach this finish line. I love you and will forever be grateful for your love and support (and am so excited to take on the supportive role as you continue to move forward in your own educational pursuits).

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Chapter 1: Introduction

In this introductory chapter, the author will introduce the area of interest of this thesis, quality improvement (QI) in healthcare from the perspective of APNs. To introduce this topic, the author situates herself, her pre-understandings of QI, previous experiences, and biases in the area of healthcare QI, thus allowing readers to understand the critical positionality of this thesis. The author proceeds to introduce the key concepts of this study: QI and APNs. Key assumptions around healthcare QI that are reflected in QI models and literature are introduced as a means of helping readers gain familiarity with the current state of healthcare QI. Current critiques of healthcare QI are also explored. Next, the author introduces APNs by exploring both their competencies and roles as well as their positionality to QI within the healthcare system. Lastly, the research aim and research question are presented and a brief overview of the critical underpinnings of the thesis that were used to achieve the research aim will be reviewed.

Pre-understandings of Quality Improvement in Healthcare

I am a Registered Nurse with six years of clinical experience in a variety of clinical settings, including community and inpatient hospital settings. I have had the privilege of working primarily at a tertiary care mental health care hospital in a rural community in Ontario, which provides a variety of highly specialized mental health services to the community and to the province, including being home to one of Canada's only high secure forensic mental health care settings. Through my educational and professional experiences in nursing, I have had opportunities to engage in quality improvement (QI) at various levels. These opportunities ranged from assisting in planning QI projects aimed at meeting accreditation standards relating to pressure wound prevention as a professional practice associate during my summer breaks from nursing school, to leading QI initiatives aimed at achieving RNAO Best Practice Spotlight

Organization designation at a community health center, to leading QI initiatives in an Advanced Practice Nursing Role for a regional specialized geriatrics service aimed at promoting senior-friendly best practices across hospital and long term care sectors, to supporting a model of care change implementation across a 15-unit inpatient hospital in a supervisory capacity. I also was exposed to a variety of QI initiatives while working as a patient-facing nurse, where improvement and change initiatives were introduced at my workplaces in response to pressures such as changes to electronic medical record systems, accreditation pressures, and the implementation of best practice recommendations. These experiences have enabled me to gain experience with and understanding of some of the pressures that drive QI in healthcare settings, the processes in place for implementing QI, and how QI impacted has me and my nursing peers, both at patient-facing and mid-level management levels. I experienced firsthand that healthcare QI often meant using pre-determined frameworks and tools to move forward documentation-heavy improvement initiatives aimed at being able to prove that initiatives are resulting in quantitative improvements. I saw how the human-resource impacts of some of these changes was often not accounted for in QI planning and instead resulted in growing numbers of to-do list and boxes to check in the electronic medical record. I saw patient-facing staff express frustrations with the negative impact of heavy documentation on their ability to engage in face-to-face care with patients.

Knowing that my research interests lie in exploring QI in healthcare, I chose to further immerse myself in the theoretical and methodological underpinnings of QI in healthcare; I thus pursued formal training in QI and obtained my Lean Six Sigma Greenbelt certificate from McGill's Business Institute in the fall of 2024, where the foundations of change management and QI were taught. This allowed me to further ground my understanding of where healthcare QI

models and theories originate and how leaders are trained to incorporate these QI frameworks within their organizations, aiding me immensely as I delved into my research.

My perceptions of QI and experiences with QI are not fundamentally negative; I appreciate the importance of being able to adapt and improve in agile ways to the complex and varying pressures that impact healthcare, especially following a global pandemic that required the healthcare sector to change and adapt at an unprecedented speed. I have immense appreciation and respect for peers and professionals who identify difficulties in their day-to-day workflows and are courageous enough to recommend changing the status-quo. I do, however, find myself frustrated with the current frameworks that confine healthcare QI, and hope to explore some of the experiences and challenges with healthcare QI through this research.

Assumptions Regarding Quality Improvement in Healthcare

This research aims to better understand the discourses that exist around HCO QI; it is therefore important to turn an eye towards the current state of HCO QI. To do so, I will explore some of the assumptions regarding QI in healthcare that form unchallenged understandings about what HCO QI is, govern how QI is carried out in HCOs, and determine how healthcare professionals working in QI are expected to carry out their work. I will explore the evidence that supports these assumptions to help better contextualize the current discourses around QI in HCOs.

The first assumption that will be examined is the idea that the standardization of healthcare delivery via QI initiatives is essential to providing good quality healthcare. This assumption is evidenced through the widespread dissemination of evidence-based practice tools and content in healthcare and through the QI methodologies that are used to bring forward improvement initiatives in healthcare. More specifically, the widespread idea that standardization

leads to good practice is evident in how widely disseminated evidence-based practice (EBP) tools are in healthcare settings amongst healthcare professionals (Bianchi et al., 2018). Best practice guidelines (BPGs) are an example of EBP tools that are widely utilized by HCOs to further EBP. BPGs, such as the ones prepared and distributed by the Registered Nurses Association of Ontario (RNAO), contain standardized quality statements about how health care professionals should provide care to patient to meet various health needs (Registered Nurses Association of Ontario, 2023). For healthcare organizations to gain "designation" status with the RNAO, a marker of quality in HCOs, they must demonstrate that they have successfully implemented the quality statements established by selected BPGs, further reinforcing the idea that standardization of healthcare produces good quality care in HCOs (RNAO, 2023). Other quality promoting organizations, such as Accreditation Canada and Health Quality Ontario (HQO) also utilize standard quality statements for HCOs to aim to achieve in their clinical practices, ranging from standardized screening practices for various illnesses to standardized clinical care pathway implementation when certain parameters are triggered (Health Quality Ontario, 2020; Health Standards Organization, 2023; Young & Smith, 2023). HCOs in Canada must regularly prove that they are meeting these standardized quality statements to be provided with an evaluation of achievement of quality standards by Accreditation Canada. Thus, much of the QI initiatives that HCOs engage in aim to meet standardized quality statements set out by health quality organizations such as the RNAO, HQO, and Accreditation Canada.

Additionally, the assumption that standardization of health care is essential to providing quality care is reflected in the QI methodologies that are used to bring about improvement in HCOs. Lean principles and Sigma Six principles, two widely utilized frameworks in HCO QI, are grounded in principles of identifying "inefficiencies" and variation with aims at promoting

increased standardization and reducing variation in healthcare practices (Kilo, 1998; Parry, 2014). The IHI, a foundational organization for QI in healthcare, calls variation in healthcare "damaging to the profession" (Kilo, 1998).

The second assumption that will be explored is the assumption that QI frameworks and methodologies that originate in other sectors, specifically management, manufacturing, and industrialism, are the necessary tools and means for achieving quality in healthcare. This assumption is evidenced by the QI frameworks and methodologies that are widely adopted by healthcare organizations to carry out quality initiatives. As previously stated, QI frameworks widely utilized in HCOs include PDSA, Lean, and Sigma Six draw origin from business, manufacturing, and include the thinking of industrial leaders and scholars, for example, Deming, Shewart, and Juran (Koyle et al., 2018; Migita et al., 2018). These frameworks have been translated for application in the healthcare sector and are used and accepted as the systematic means for achieving QI in HCOs. This assumption is further illustrated by the ways in which healthcare leaders are expected to participate in leadership development and education that focuses on QI frameworks, including Lean, in order to be better prepared to carry out and support QI initiatives in HCOs in their leadership roles (Ingelsson et al., 2020; Worsley et al., 2016).

The last assumption that will be explored is the assumption that QI in healthcare must be leadership driven and requires organizational leadership to set and achieve quality measures in HCOs. This assumption is illustrated in the way that QI models are developed in healthcare. For example, in 1998, the IHI put forth a groundbreaking QI model titled the "Breakthrough Series" (BTS) to be used as a guide for HCOs looking to accomplish QI (Kilo, 1998). One of the foundational elements of the BTS model is that organizational senior leadership must identify

their support and strategies for achieving QI, illustrating that QI is leadership driven, rather than patient-facing clinician driven, by design (Kilo, 1998). QI training and QI grounded leadership development is often a knowledge, competency, and practice expectation for healthcare leadership, but not a necessarily a competency expectation for patient-facing clinicians, further solidifying the assumption that HCO QI rests primarily with leadership rather than clinicians (Solbakken et al., 2020).

Current Critiques of Quality Improvement in Healthcare

Despite being a widely accepted and unchallenged practice in the healthcare system, the role of QI has been critiqued by a small number of healthcare and nursing scholars. The measures that QI initiatives adhere to have been critiqued, particularly the quality measures around improving cost figures and value. Luce et al. (1994) identify that physicians have raised concerns over QI initiatives for paradoxically prioritizing cost containment over quality of healthcare delivery. Concerns have also been raised that QI is often HCO management and leadership driven rather than clinician driven, highlighting the risk of disconnect between management and clinicians in terms of how improvement is defined and executed in healthcare (Banerjee et al., 2012). Nursing-centered critiques of QI have explored how nurses are strategically enrolled in to regimes of efficiency and effectiveness by way of QI dissemination; this results in the nursing workforce actively participating in the bureaucratization of nursing care and being enrolled to identify efficiencies in the “mundane” aspects of nursing care, without consideration for what benefits, including temporary rest and reprieve, these “mundane” tasks bring to an already resource-limited workforce (Rudge, 2013).

QI has also been critiqued for introducing unexpected areas of harm in the pursuit of improvement in healthcare. Schroder et al. (2019) highlight this phenomenon by exemplifying

the negative impact that improvements in healthcare technology have had on time allowed for direct nurse-patient care, which can serve to erode other important aspects of nursing work, notably, relational practice (McMillan & Perron, 2020b). Additionally, advances in healthcare technology have also introduced unexpected harm to patients in the form of healthcare data breaches which have become increasingly frequent with increases in health technology QI initiatives (Seh et al., 2020). Since 2005, more than 250 million individuals have been impacted by healthcare data breaches on a global scale (Seh et al., 2020).

One of the most sobering critiques of QI in healthcare is that over the last several decades, QI initiatives often do not succeed at making the quantitative improvements that they aim to achieve in through their efforts in improving quality (Schroeder et al., 2019). Despite the largescale, comprehensive, ongoing efforts of QI initiatives, and immense amounts of funding allocated to reduce medical errors through quality improvement, errors continue to occur, quantitative standards continue to not be met.

QI in healthcare contributes to continuous and rapidly changing workplace environments for nurses and other health professionals, putting them at risk of negative consequences associated with workplace change including change fatigue, burnout, emotional exhaustion, anxiety and frustration (Mandel & Cady, 2022; McMillan & Perron, 2013, 2020a). QI in healthcare has been critiqued for contributing to increased nursing turnover during periods already characterized by nursing shortages (Shannon & French, 2005).

Avedis Donabedian, whose work was foundational in moving forward QI in healthcare, highlighted an important caveat for the consideration of QI in healthcare, specifically the importance of maintaining the human aspect of quality and not losing sight of it in the larger picture of improvement (Ayanian & Markel, 2016). Donabedian went on to describe that “health

care is… not a fundamentally commercial [enterprise]. We are not selling a product" (Ayanian and Markel, 2016). The loss of humanization of QI in healthcare in its current form is another important shortcoming that has been identified by healthcare scholars, who describe how QI has gone on to prioritize the performance of measures rather than the experiences of those who participate in QI (Mandel & Cady, 2022). Mandel & Cady (2022) highlight the challenges associated with the current utilization of QI in healthcare, which they describe as an environment of "buzzwords" rather than a driver of improvement, and an environment that is process oriented and focused on quantitative productivity, rather than socio-behaviourally oriented, where the focus is on the emotional experiences of those in the system.

Advanced Practice Nurses and Quality Improvement in Healthcare

Advanced Practice Nurses (APNs) are specialized nurses with clinical expertise in a particular area of nursing and who through additional studies, have obtained a graduate degree in nursing (Canadian Nurses Association, 2019; International Council of Nurses, 2020). The role of the APN first formally emerged in Canada and the USA in the 1960s when there was a need identified for specialized nurses to help address health system gaps in rural and underserved communities. Since then, expansion of the APN role has been called for to also address increasing complexity of patient care and to help move forward the evidence-based care movements emerging in the healthcare sector (ICN, 2020 & CNA, 2019). In Canada and globally, APNs are delineated into two distinct professions, Clinical Nurse Specialists (CNSs) and Nurse Practitioners (NPs).

In Canada, NPs are Advanced Practice Nurses, who, through the completion of NP graduate studies, have the knowledge, skills, and legislated authority to practice as autonomous healthcare providers who can diagnose, order and interpret diagnostic tests, prescribe treatments

(including prescription medications), and perform specific procedures related to the care of individuals in various settings (CNA, 2019). NP is a protected title in Canada and regulated in each province and territory (CNA, 2019). NPs in Canada also have the skills and knowledge to fully practice the general APN competencies that are identified in the Canadian Nurses Association (CNA)'s 2019 *Advanced-Practice Nursing pan-Canadian Framework*, which are as follows: direct clinical care, leadership, education, research, health systems optimization, and consultation and collaboration.

CNSs do not use medical diagnoses or treatment as central to the focus of their autonomous care provision (as NPs do), however they do have the knowledge, skills, and preparation to provide autonomous expert consultation on complex clinical cases, to support interdisciplinary staff education needs, to critically appraise healthcare research, and to influence change in the healthcare system (CNA, 2019; ICN 2020). There is also an expectation that CNSs practice the full scope of APN competencies as outlined by the 2019 CNA *APN pan-Canadian Framework*.

In Canada, the practice of NPs largely centres on direct clinical care due to their ability to address healthcare provider gaps in Canada (CNA, 2019). Their role in the planning and implementation of organizational QI initiatives is less clear. Review of the literature suggests that their role in QI work is more limited, and instead most literature discussing NPs and HCO QI looks at evaluating the benefits and impact of introducing a single NP to a singular care setting wherein NP integration *is* the QI project, with attention to how the introduction of an NP can increase time and cost efficiencies in various care settings (Ryder et al., 2020). There is little research available that explores the role *of* NPs as drivers of QI initiatives, indicating that there

may be some ambiguity as to how NPs engage in QI work and whether NPs consider themselves as leaders in healthcare transformation and HCO QI (Ryder et al., 2020).

Contrarily, the role of the CNS consists of a larger mix of both direct and indirect care (CNA, 2019 & ICN, 2020). Due to their specialized skills and educational preparation, HCOs have identified CNSs as nursing leaders who can aid in the leadership, planning, and implementation of QI initiatives in HCOs as well as move forward EBP initiatives into clinical practice (CNA, 2019; ICN, 2020). Increasingly, across different HCOs, the expectation has become that healthcare leaders, including CNSs, are now required to help create environments that foster QI and ensure improvement is pursued and achieved (Schroeder et al., 2019). When examining the APN competencies for Canadian CNSs, there are many areas where their roles as change leaders are identified, including their competencies in health systems optimization (which include healthcare system gap identification and change management), their educational competencies (which include the planning and initiation of educational programs based on identified organizational needs), and their leadership competencies (which include the initiation of system change to respond to organizational needs) (CNA, 2019). This further demonstrates how both CNSs and HCOs have identified the CNS role as highly advantageous to QI processes.

Despite having an expectation to engage in HCO QI initiatives, APNs are not required to pursue any kind of formal QI specific education during their graduate studies, as QI education is grounded in business theory rather than nursing centered. APNs complete graduate studies in nursing, with a minimum standard of a Master of Nursing (CNA, 2019 & ICN, 2020). In Canada, nursing education standards are predominantly established by the Canadian Association of Schools of Nursing (CASN) (Canadian Association of Schools of Nursing, 2022). While CASN identifies some educational domains that discuss change in healthcare, including learning

outcomes for knowledge mobilization and outcomes related to responding to health service and system issues via policy and program change action, there is no domain or knowledge outcome that relates specifically to the development of QI skills and knowledge (CASN, 2022). Nurses who pursue graduate degrees are not guaranteed exposure to QI related concepts. The way that graduate nursing education is currently structured means that qualified APNs may be hired into roles with an expectation to engage in QI work despite never having received any formal training in QI theories, principles, and methodologies that are frequently used across HCOs.

Furthermore, while the CNA establishes the educational expectations for CNSs in Canada, it is important to note that CNS is currently not a protected title in most provinces and territories in Canada, including Ontario, where this research is based (CNA, 2019). The result of this is that while the CNA expectation is that CNSs are Masters prepared, in many workplaces in Ontario, nurses may be practicing in CNS roles without having currently obtained a graduate degree in nursing, adding further nuance to the educational background profiles of individuals working in these roles.

While the competencies of NPs and CNSs have many similarities, their roles in practice differ significantly (CNA, 2019; ICN, 2020). As identified, when examining QI in HCOs, CNSs are more likely to be engaged in this type of work on a regular basis in HCOs compared to NPs due to their differing scopes, roles, and responsibilities in the healthcare system. For these reasons, the purpose of this research will be to examine the perspectives of CNSs in their experiences with QI work in HCOs.

Research Aim

Broadly, this thesis' research aimed to explore QI discourses from the perspectives of Clinical Nurse Specialists (CNSs). More specifically, the aims of this research were to explore

and identify the dominant discourses that structure QI in healthcare, how these discourses impact the nursing work and experiences of APNs, as well as to identify and bring attention to alternative or subjugated discourses regarding QI that may exist in healthcare. Foucauldian conceptualizations ground the researchers understanding of discourse, which can be broadly understood as historically locatable, structured ways of thinking, speaking, and relating to a topic that both enable and limit what we know about that topic in specific social areas (Cheek, 2004; McHoul & Grace, 1993, p. 37). Discourse and the other Foucauldian concepts that underpin this study will be explored in more detail in this thesis' theory chapter (Chapter 3).

This aim was largely achieved by exploring the perspectives of CNSs in relation to their experiences with QI in hospital-based settings. As has been explored so far in this introduction chapter, CNSs hold a unique positionality within the healthcare sector as nursing leaders and experts in clinical care, providing a lens from which QI can be explored. To achieve the research aim, CNSs lend a voice and provide a tableau of experience from which the discursive construction of QI in healthcare can be uncovered. The unique lens of CNSs with respect to experience within QI has not yet been explored, creating a research gap that was addressed via the aim of this thesis. Therefore, the following research questions were asked:

1. How do CNSs experience QI in their nursing work?
2. What are their roles as CNSs in QI?

While these questions are experiential in nature, they still lended to the overall research aim due to the social and experiential nature of discourse. By asking the above two questions, insight was gained about the forms of knowledge, ideas, and speech that shape QI work in healthcare settings, thus allowing the following research questions to be answered:

1. What are the prominent discourses that shape current understanding of and experience with QI in healthcare?
2. What forms of subjugated knowledge and discourse emerge in QI-centered spaces in healthcare organizations?
3. How do QI discourses in HCOs shape the experiences of APNs in their professional capacity?

Utilizing a Foucauldian inspired framework for the examination of discourses, this author was able to examine how QI in healthcare has been conceptualized over time, how ideas and knowing around what QI is have emerged in HCOs, how this knowledge became consolidated over time and how different strategies and techniques have been used to legitimize QI discourses in healthcare, subsequently shaping behaviors and thoughts of healthcare workers engaged in QI. This author applied Mitchell Dean's governmentality analytic framework to accomplish these aims by employing two analytic methods: Genealogical analysis of healthcare QI framework documents and analysis of semi-structured interviews with Advanced-Practice Nurses.

Summary

In this thesis' introduction, the topic of healthcare QI is introduced. As the author to this study, I situate myself in my pre-understandings and previous experiences with healthcare QI. Assumptions that ground healthcare QI, notably reduced variability as improvement, the translation of industrial/management QI models to the healthcare industry being essential to moving forward improvement initiatives, and QI being leadership-driven are discussed. The attributes, roles, and capacities of APNs and their role in QI were then discussed. Lastly, the

research aim and research questions of this thesis were presented along with a brief overview of the methods that were used to achieve these aims.

Chapter 2: Literature Review

As a means of situating myself within the body of literature exploring the ways in which APNs and nurses as experience QI, a literature review on the subject was completed. The literature review was done using traditional literature review methodologies which consist of clearly defined search terms and inclusion/exclusion criteria and involves organizing the results in a thematic manner (Carnwell & Daly, 2001). This is reflective of the chronological evolution of this thesis; the thesis' methodology was not known at the outset of the literature review, therefore an overview of the literature more aligned with critical discourse analysis methods was not completed. Despite the literature review methods being more in line with a traditional thematic approach, a critical discursive interpretation of the reviewed literature is evident, notably in the presentation and discussion of themes. These include the experiences of nurses as they are impacted by QI, current issues surrounding healthcare QI, and an examination of how HCOs benefit from the implementation of QI in their organizational structures.

Search Strategies

A comprehensive search of the literature was conducted to better understand the research to date exploring the APNs experience working in QI. Searches were completed in CINAHL, PubMed, Scopus and ProQuest using combinations of the following search terms: "quality improvement" OR "organizational change;" "lived experience" OR "life experiences;" "Advanced Practice Nursing" OR "Advanced Practice Nurses" OR "Advanced Practice Nurse." Inclusion criteria for article selection were as follows: articles published in English; all accessible date ranges; inclusion of texts available through uOttawa's library database, articles that examined the experiences of nurses experiencing QI initiatives and/or organizational change initiatives. The search was expanded beyond the inclusion of only APNs to also include the

experiences of other nursing professionals, including nursing managers, nursing leaders, nursing educators, and patient-facing nurses, as results exploring the perspectives of APNs were very limited. Articles that explored the working and professional experiences of APNs and their role in QI were also included. Articles were excluded if they were not available in English or if they did not explore the experience of nurses as they are exposed to QI or organizational change and instead examined experience of healthcare service users such as patients and families, as they were exposed to QI. Theses and dissertations were also excluded. From the preliminary search of the journals using combinations of the identified search terms, 653 articles were selected for title and abstract review. Inclusion/exclusion criteria were applied to these results and duplicates were removed, resulting in a total of 48 articles selected for full review. 21 articles were included after full body review of the literature, as 27 of the articles did not meet inclusion criteria.

The articles can be broken down by the following characteristics. Of the 21 articles, 15 were research studies that included multiple participants, with sample sizes ranging from 8 to 95 participants per study. Two of the articles were literature reviews, and the remaining four articles were authors' self-reports of their working experiences in various advanced practice and nursing leadership roles. Articles examined were written by authors in settings from countries across the world, including three from the USA, four from Canada, two from South Africa, three from the UK, three from Norway, and one from each of the following: Australia, Denmark, Sweden, Finland, and Turkey. The studies looked at nurses and healthcare professionals from various practice settings, including hospitals, long term care homes, nursing educational institutions, specialist care, primary care, municipal health and sports medicine.

Consistent motifs and discursive constructions were extrapolated from the literature which will be explored in detail in this chapter.

The Discursive Construction of Advanced Practice Nurses as Quality Improvement Professionals

Across the literature, the identification of APNs (both NPs and CNSs) as professionals who are well-positioned to engage in HCO QI initiatives was prominent (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018). Several subthemes arose with respect to the construction of APN identity as well-positioned professionals in QI initiatives, which will be explored in this section.

Clinical Expertise of APN

The literature heavily explored the idea that APNs possess a high level of clinical expertise which enables them to be well-positioned to engage in and support QI work in healthcare settings (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018). Authors highlight the high degree of clinical expertise that APNs possess allows them to understand the intricacies of patient care and identify areas for improvement. The nature of the APN and their scope of practice, particularly when it comes to their direct clinical care competencies, allows APNs to have ongoing exposure to direct clinical care, enabling them to remain knowledgeable and connected to relevant clinical care issues (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018). It was also identified that having direct exposure to clinical care allows APNs to remain connected and collaborative with their clinical care provider partners, thus allowing them to have ongoing knowledge of clinical care provider values (Aplin, 2020; Diaczun & Miller, 2023; O'Sullivan, 2022; Schoales et al., 2018). This direct exposure to clinical care and high degree of familiarity of care provider values allows APNs to advocate for and

participate in change initiatives that address issues that are relevant and valuable to the care team.

APNs as Beneficial to QI Aims

APNs were also identified as good candidates for participation in QI initiatives due to their leadership skills. In the Canadian Nurses Association (CNA)'s *Advanced Practice Nursing: A pan-Canadian Framework*, leadership is identified as one of the five core competencies of APNs and CNSs (Canadian Nurses Association, 2019). Leadership as a core competency for APNs enables a degree of accountability for APNs to be strong leaders in their workplaces and when engaging in professional duties, which may include QI. Aplin (2020) identifies that effective leadership is a requirement for moving forward QI initiatives in the clinical setting. The literature identifies APNs as professionals with unique and desirable leadership qualities, which tie back directly to their foundations in direct clinical care (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018). According to Diaczun and Miller (2023), APNs' clinical practice experience translates to strong relational leadership skills, which can be valuable in moving forward QI initiatives as these skills can help to foster trust, collaboration, and teamwork within the interprofessional healthcare team. APNs and their competencies also set them up to be strong collaborative leaders. Collaboration is an essential part of the APN role, as evidenced by "consultation and collaboration" being identified as one of the CNA's core competencies of the APN (Canadian Nurses Association, 2019). Strong collaborative leadership is essential in effective QI and change management within organizations, enabling APNs to leverage their skills and competencies to position themselves as strong QI leaders in HCOs (Diaczun & Miller, 2023; Lewandowski & Adamle, 2009).

The role and competencies of an APN also allow them to be leaders at multiple levels in the healthcare system. Their role in direct clinical care enables them to be strong leaders at the patient level (Aplin, 2020; Lewandowski & Adamle, 2009; O'Sullivan, 2022). The role of the APN allows them to have unique system leadership positionality in the context of bedside leadership skills (Lewandowski & Adamle, 2009). Through the practice of interprofessional collaboration and high visibility with the clinical care team, APNs are well-positioned to be informal leaders at the clinical care level (Aplin, 2020; Lewandowski & Adamle, 2009; O'Sullivan, 2022). Informal leadership at the clinical level can help to influence change, as evidenced by the employment of informal change leaders in several change management models, including the need for "credible and influential peer champions for the change" in change management processes, as identified by the Registered Nurses of Ontario (RNAO) in their change management frameworks (Registered Nurses Association of Ontario, 2023). Their positionality as healthcare leaders also allows them to engage in more formal leadership within healthcare organizations, leveraging their knowledge of organizational priorities and business language to propose, advocate for, and model change at a higher leadership level (Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; Schoales et al., 2018). The unique ability to act as leaders as different levels within the healthcare system allows for APNs to translate clinical issues into organizational business plans and business plans back to clinical relevancy depending on the audience they are targeting, making them invaluable QI team members (Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; Schoales et al., 2018).

In addition to the leadership strengths that come with the APN role and full application of its competencies, the literature identified APNs as leaders who are well-positioned to utilize validated change leadership frameworks in their practices, including Leads (Diaczun & Miller,

2023). The ability to apply change leadership frameworks in a professional capacity positions APNs as valuable leaders to healthcare organizations where leaders are expected to train in and apply these validated change leadership frameworks.

APN Power as strength in mobilizing QI

One study explored the concept of power in the experiences of CNSs in the healthcare system. In this study, power was described as an asset that CNSs develop over time that can contribute to effective QI and change management leadership in their practices (Schoales et al., 2018). The CNSs in the study acknowledged that their degree of clinical expertise contributes to a higher level of credibility among interprofessional peers (Schoales et al., 2018). From the perspective of the participants, this increased level of clinical credibility is directly tied to their experience with power within the healthcare organization (Schoales et al., 2018). They also acknowledged that power was an essential part of moving forward change initiatives in HCOs and their ability as CNSs to make a difference within the organizational setting at a leadership level (Schoales et al., 2018). They described power as existing on a spectrum, which can fluctuate over time with experience and increased competency in their role and as they are exposed to different leadership experiences (Schoales et al., 2018). The fluctuating nature of power in this context can be summed up in the following quote from a participant in this study: “In the APN role you have a lot of power inherently, and as you develop that role, and develop your expertise, and people become more aware, then your power increases” (Schoales et al., 2018, p. 102). The experience of increased power perceived by CNSs was described as “power creep” by the researchers, who acknowledged that power creep contributed to increased ability to influence change and engage in QI in healthcare settings (Schoales et al., 2018, p. 102).

Educational Preparation of APNs

Many of the studies examined the educational preparation of APNs as it relates to APNs ability to be effective in change management and QI in HCOs. Master's level education is identified as an "underpinning" to advanced practice (Aplin, 2020). Similarly, while the CNA acknowledges that the CNS role does not hold title protection, they also identify Master's preparation in nursing as a core educational precursor to advanced practice nursing in Canada (Canadian Nurses Association, 2019). Schoales et al. (2018) identify the educational preparation of APNs as a strength, suggesting that APNs can apply their graduate education to help improve the healthcare system and health outcomes. Schoales et al. (2018) also identify that the graduate level education of APNs increases levels of trust towards APNs. Trust is identified as an essential part of effective change management, thus additional educational preparation of APNs can help to positively contribute to change and improvement in HCOs (Schoales et al., 2018). With regards to CNSs, the foundational clinical leadership skills inherent in their roles can be translated to the system level when they are provided with system leadership opportunities that allow them to practice at their full scope (Lewandowski & Adamle, 2009). In the literature examined, organizations recognizing APNs, including CNSs and NPs, as strong and effective leaders is a necessary precursor to the ability of APNs to engage in QI to the full scope of their abilities (Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018).

Quality improvement and change management preparation for nurses

When examining the literature regarding the experiences of nursing professionals, inclusive of nursing managers, change leaders, educators, and direct clinical care nursing staff, as they experienced QI initiatives and organizational change, several themes arose.

Nursing Managers' preparation in QI and change management

Several studies noted that nursing managers identified many challenges with respect to their transitions to nursing management roles and their ability to guide staff through periods of organizational change (Bianchi et al., 2018; Knight, 1998; Morrison & Jensen, 2022; Nghe et al., 2020). Nghe et al. (2020) highlight that research shows that when examining the experiences of healthcare leaders with a range of professional designations and backgrounds, most identify that they were poorly trained in leadership skills and even fewer received formal training in management skills. This is consistent with the research done by Solbakken et al. (2020), which identifies that nurses do not necessarily receive any additional education or training when they transition from nurse clinician to nurse patient-facing managers in HCOs. When examining the experiences of nursing managers relating specifically to their roles in supporting organizational change, Morrison and Jensen (2022) identify that nursing managers held the perception that they lacked options for supervision and mentorship during periods of change. Another study examining the experiences of nurse managers in HCO organizational change identifies that nursing managers perceive that their difficulties in change management leadership are related to insufficient personal and professional skill development in change management (Nghe et al., 2020). Bianchi et al. (2018) also identify shortages with regards to nursing leadership preparation in QI and change management, identifying that many nurse managers are not adequately equipped to lead QI and change initiatives as they lack formal preparation and skill development in this area of practice.

Need for QI and change management education

A theme that arose in the literature was an identified need for more QI and change management education for nurses and healthcare leaders. In a study, nursing leaders identified

that there was a gap in nursing leadership preparation relating to change management and knowledge to practice translational skills (Nghe et al., 2020). They identified a need for consistent and structured education and training to address this gap in preparation (Nghe et al., 2020).

Impacts of QI and change management education

Two of the studies identified in this research directly examine the impacts of education relating to leadership development, including change management skills development, on nursing leadership. Nghe et al. (2020) researched the efficacy of a leadership development program for middle-level nursing managers. When discussing results relating to the participants' self-perception of confidence relating to "acting as a change agent" in their leadership roles, researchers found that participation in the leadership development summit had a positive impact on self-rated confidence (Nghe et al., 2020, p. 487). The researchers did acknowledge, however, that there are limitations in the design of their study as the self-rated levels of confidence in "acting as a change agent" were only evaluated immediately after participation in the leadership development summit and not after participants had been acting in leadership positions for a period of time following the development summit, potentially creating a bias in the results of the study (Nghe et al., 2020, p. 487). Bianchi et al. (2018) also identified that the completion of a leadership course had positive impacts on leadership effectiveness. However, they highlighted the inconsistencies across various healthcare organizations with respect to requirements for leadership course completion or leadership preparation, suggesting that nursing leadership competencies vary greatly across the healthcare system.

Impacts of insufficient QI and change management preparation on leadership

Nursing managers and leaders identified significant impacts and difficulties relating specifically to their insufficient preparation in QI and change management (Knight, 1998; Morrison & Jensen, 2022). Morrison and Jensen (2022) identified in their study that nursing managers expressed feelings of abandonment during periods of change in healthcare organizations relating to their lack of options for supervision and mentorship with regards to change management. Knight (1998) identified that insufficient skills and knowledge related to change management are a large contributor to nursing managers' difficulties surrounding experiences of change and leading change. Some of the difficulties surrounding periods of change that were identified include feelings of abandonment, isolation, and concerns with lack of control with regards to change processes, which nurse managers perceive as being related to their knowledge gap in the change management process (Knight, 1998; Morrison & Jensen, 2022).

Change Leader exclusion from quality improvement planning

Throughout the literature, nursing change leaders and change agents expressed a notable lack of involvement in change planning processes, creating a sense that QI and organizational change is hierarchical and occurs without sufficient input from the impacted parties, including input of those responsible for implementation of such change and input of patient-facing staff responsible for carrying out the change (Abrahamson et al., 2013; Ericson-Lindman & Strandberg, 2021; Frilund et al., 2023; Knight, 1998; Magadze et al., 2022; Morrison & Jensen, 2022; Solbakken et al., 2020; Steinskog et al., 2021; Wagstaff et al., 2015).

One study explored the benefits of involving staff in quality improvement and change processes. Abrahamson et al. (2013) explored the impacts of actively engaging staff, including clinical change leaders, in a QI project in a long-term care (LTC) setting. The study identified

that engaging staff in the QI planning process, including allowing opportunities for staff to express their thoughts and concerns relating to the QI project during the planning and implementation phases to be a positive influence on the success of the project (Abrahamson et al., 2013). This positive impact, however, was found to be conditional on how responsive the LTC leadership team was to the concerns that were brought up by staff, including concerns about how the QI project had impacted workflow (Abrahamson et al., 2013). The positive benefits of including staff in planning were realized when leadership was flexible and how well they worked to meet staff needs throughout the change implementation process (Abrahamson et al., 2013).

Many other studies identified significant gaps in change leadership involvement in the QI planning process. Many nursing leaders described challenges with regards to level of authority and voice in QI and change planning processes in their organizations (Ericson-Lindman & Strandberg, 2021; Frilund et al., 2023; Morrison & Jensen, 2022; Solbakken et al., 2020). Nursing leaders in one study identify difficulties with navigating their role in change management planning, citing perceptions of "feeling forgotten" in the process (Frilund et al., 2023). One nurse leader identified that she "thought [she] would have the opportunity to develop this" in relation to the change planning process, however identified barriers relating to a more traditional, physician-led style of leadership rather than collaborative leadership and decision-making in their organization (Frilund et al., 2023, p. 5427). Ericson-Lindman and Strandberg (2021) identified that change leaders in a residential care setting for older adults did not participate in the change management planning process but were responsible for implementing and championing change goals that they were not involved in determining.

Themes surrounding non-collaborative leadership and QI planning were consistent across several articles. In one study, patient-facing nursing managers reflecting on their experiences

with healthcare reforms identified that higher leadership employed “command and control type of communication and leadership” in order to move forward change initiatives, which contributed to difficulties with regards to the way they managed change initiatives as managers guiding their patient-facing staff (Solbakken et al., 2020, p. 211). Morrison and Jensen (2022) also identified difficulties with regards to the ways in which nursing managers are involved in change planning and implementation in healthcare organizations. Nurse managers in this study identified that there was significant lack of collaboration and nurse manager involvement in the change management process, resulting in frustrations (Morrison & Jensen, 2022). Furthermore, the nurse managers identified that several gaps in communication existed between leadership teams leading the change management process and nursing managers, including not providing sufficient information about the vision for, and purpose of the change (Morrison & Jensen, 2022). This lack of vision and clarity contributed to difficulties with managing change with patient-facing staff, as nurse managers felt unprepared to answer questions relating to the change management process amongst staff (Morrison & Jensen, 2022). Lack of involvement in change management also contributed to discouragement amongst nursing managers, who described the challenges associated with having to lead staff through changes by explaining decisions that they had no involvement in and defending a vision for change that they had little influence on (Morrison & Jensen, 2022). Results in Wagstaff et al.'s (2015) study mirrored these results, as sports medicine leaders going through a period of change identified strong perceptions of lack of involvement and consultation with regards to the change planning process. This non-collaborative approach to change planning resulted in a culture of uncertainty and speculation amongst staff (Wagstaff et al., 2015). The lack of involvement and perceived poor communication noted in this change process also resulted in unclear goals with regards to the

change, which was described by leaders involved in this study as “demotivating” to the change management process (Wagstaff et al., 2015, p. 691).

Following the exploration of how HCO leadership teams do not engage staff and change agents in QI project planning, Magadze et al. (2022) highlighted some potential consequences that can result from this non-collaborative approach. They highlighted in particular that by not engaging change agents and patient-facing staff in the QI process potential gaps in two-way communication are created (Magadze et al., 2022). In addition to the communication gaps perceived by staff who are on the receiving end of change, which have been described so far in this section, there are also communication gaps that have the potential to impact leadership (Magadze et al., 2022). When leadership does not engage change agents in QI planning process and does not foster collaborative communication with their staff, it creates conditions where existing systematic shortages that negatively impact change initiates are not brought to light, thus contributing to change failure. (Magadze et al., 2022). These blind spots in information and communication can result in reactive rather than proactive approaches to QI management and implementation and can contribute to the implementation of QI projects that may not be sustainable in the long term (Magadze et al., 2022).

Incongruence in clinical priorities and organizational priorities

Both change leaders and patient-facing staff identified a perceived sense of disconnect between clinical and organizational priorities during QI and organizational change initiatives (Ericson-Lindman & Strandberg, 2021; Frilund et al., 2023; Knight, 1998; Morrison & Jensen, 2022; Schoales et al., 2018), which will be elaborated on in the below sections.

Perceived Increased Control

In some studies, themes surrounding staff perceptions of QI being used as a tool to increase control over staff were identified. One study exploring the experiences of change leaders in the implementation of a QI project in an older adult residential care setting found that change leader participants identified that their patient-facing peers communicated to them concerns over the change process and the changes being implemented (Ericson-Lindman & Strandberg, 2021). Peers described the change management process as "threatening" and saw the changes as means for management to increase their control over staff rather than being motivated by aspirations to improve patient care (Ericson-Lindman & Strandberg, 2021, p. 153).

Difficulties with maintaining person-centred care

Several studies identified themes surrounding the incongruencies between organizational priorities in QI and the values of person-centered care. Nursing professionals voiced concerns about how the disconnect between clinical priorities and organizational priorities may contribute to deterioration in client-centred care, as evidenced by the metric, efficiency, and cost-driven ways that organizations measure improvement during change initiatives (Ericson-Lindman & Strandberg, 2021; Frilund et al., 2023; Morrison & Jensen, 2022; Schoales et al., 2018). Participants highlighted their critiques surrounding the tools that are used to measure quality and improvement during QI initiatives in HCOs, describing them as "blunt and standardized" (Ericson-Lindman & Strandberg, 2021, p. 153). The participants described how HCOs focus on metric-oriented quality evaluation contributed to ethical dilemmas for healthcare professionals, as the metrics do not consider the complex context of care delivery that they experience in their workdays (Ericson-Lindman & Strandberg, 2021). One example of this noted in the study included facing pressures from HCO leadership to implement QI-derived interventions that did

not consider factors such as patient autonomy and the person's right to refuse care and interventions (Ericson-Lindman & Strandberg, 2021).

Another study found similar themes (Frilund et al., 2023). They described the pressures they faced to create "result units" which resulted in the nurse managers feeling they needed to abandon patient care in place of achieving the QI targets set out by the organization (Frilund et al., 2023, p. 5427). One participant summed up their perception of the situation by reflecting that "it appeared that political decision-making and economic realities often constitute motivations for change rather than aspects related to culture or quality" (Frilund et al., 2023, p. 5428). Participants in a different study also identified perceptions that QI is often politically motivated, describing how the direction of public health services are guided by politicians, which can go on to create conflicts in values between public administration paradigms and healthcare paradigms (Morrison & Jensen, 2022). Participants described how these conflicting values translated to the workplace in HCOs, stating that QI often resulted in a focus on increasing productivity rather than a focus on patient care (Morrison & Jensen, 2022). The nurse managers in the study described feeling pressured to compromise their core nursing values for the sake of attaining the QI goals set out by HCO corporate leadership, contributing to ethical dilemmas in their practice (Morrison & Jensen, 2022).

Staff who lived through a period of change relating to QI in an older adult residential care setting also identified concerns with regards to how QI initiatives often increased their volume of non-care related work, which raised concerns surrounding the resulting deterioration of person-centred care (Ericson-Lindman & Strandberg, 2021). Staff identified that during periods of QI related organizational change, new duties and assignments are often added while others are not removed in place (Ericson-Lindman & Strandberg, 2021). They identified how these QI-related

additions to their workload often resulted in difficulties with completing basic resident-centred tasks, such as activities of daily living (ADLs), which they felt was essential to good person-centred care (Ericson-Lindman & Strandberg, 2021).

In response to the incongruencies in organizational and clinical priorities, staff identified the need for alternatives methods of measuring quality of care in HCOs that adequately captured clinically oriented values and priorities (Ericson-Lindman & Strandberg, 2021). Staff identified the need for wider range of data collection in QI projects, including "soft data" that reflects subjective, person centered descriptions of what "good care" consists of (Ericson-Lindman & Strandberg, 2021, p. 153).

Conflicts in APN priorities versus organizational priorities

NPs also identified difficulties with regards to showcasing their role value in QI initiatives in healthcare organizations due to incongruence in clinical priorities and organizational priorities. In one study, NPs identified that the traditional, metric-based measurements that are used to gauge quality and measure improvement in HCOs made it difficult to translate the successes that they saw in their clinical-care oriented improvement work to corporate leadership (O'Sullivan, 2022). While the NPs were able to qualitatively describe successes and the value of their clinical-oriented work, it was more difficult to translate that to metric-based evaluation, meaning that these roles could be vulnerable to not being recognized as valuable (O'Sullivan, 2022).

Other APNs, particularly CNSs, also described difficulties with navigating ways to move forward more clinically oriented improvement initiatives in the face of corporate priorities. They described how corporate priorities including funding, resource constraints, and organizational

business review metrics were prioritized over clinical priorities including program, staff, and client needs (Schoales et al., 2018).

QI for Resource Management

The literature also highlighted incongruencies in organizations resource management priorities when compared to the priorities of healthcare workers (Andrews et al., 2020; Ericson-Lindman & Strandberg, 2021; Morrison & Jensen, 2022; Schoales et al., 2018). Healthcare workers identified frustrations with HCOs budget-oriented framing of QI projects, highlighting that conflict often occurred between leadership and staff in this regard (Morrison & Jensen, 2022). One example discussed the frustrations that occurred when staff advocated for their perceived needs for more staff and human resources as a result of the increased work volume from QI initiatives and were met with resistance from leadership due to budgetary constraints (Ericson-Lindman & Strandberg, 2021).

There were also frustrations identified with organizations' perceived lack of willingness to acknowledge institutional barriers to successful change and QI implementation, including needs for expanded time allocation, increased budget allocation, human resources and staffing need implications, and staff scheduling implications (Ericson-Lindman & Strandberg, 2021; Morrison & Jensen, 2022). Staff described how QI projects often left them feeling they did not have enough time to do all that was being asked of them, a problem which was exacerbated by the perception that during periods of QI and change new duties and assignments are added while others are not removed in place (Ericson-Lindman & Strandberg, 2021). Staff also highlighted frustrations with regards to human resource management elements in QI projects, including lack of consultation with staff with regards to changes that may impact staff quality of life at work and outside of work, such as schedule changes (Ericson-Lindman & Strandberg, 2021).

Hierarchies in Healthcare Quality Improvement

Several themes arose surrounding perceived hierarchies and their impacts on QI in HCOs. The hierarchical structures in HCO QI processes contribute to perceptions among nurses that QI in healthcare "comes from the top" (Ericson-Lindman & Strandberg, 2021). This top-down structure results in senior leadership holding power to decide whether or not authority will be given to patient-facing staff to move forward clinically driven QI projects, creating barriers for grassroots-led improvement initiatives (Locock et al., 2021). Several tensions between leadership and patient-facing priorities that contribute to these barriers were identified, including patient-facing staff eagerness to include forms of "soft" intelligence, such as patient stories, informal comments, and general ward experiences in their QI plans, despite leadership's tendencies to disregard this type of information as "data" (Locock et al., 2021). Ericson-Lindman and Strandberg (2021) found that negative perceptions of hierarchy in relation to HCO QI contributes to feelings of alienation in the workplace among patient-facing staff.

HCO QI structures contribute to imbalances with regards to how QI initiatives are prioritized. Many studies explored the perception that finding organizational support for patient-facing driven change that is meaningful to nurses and clinicians is challenging at many levels due to organizations' embedded hierarchies. These organizational hierarchies often produce leadership teams driven by system or corporate priorities and constraints, which determine QI priorities, thus creating barriers to clinician-driven QI (Locock et al., 2021). One study also found when exploring efficacy of QI in healthcare settings, interprofessional QI teams with whose membership consisted of mixed professional backgrounds, including physicians, managers and nurses, were more effective at moving forward QI initiatives compared to teams that consisted mostly of nurses (Locock et al., 2021). They identified that when senior leaders

were a part of the QI teams, the teams were more skillful in their ability to mobilize organizational support, successfully apply pressure to leadership for change, and draw in additional resources, including financial resources, to make their QI projects successful compared to QI groups that unilaterally consisted of nurses. This could suggest that having multiple levels of hierarchy in a QI planning and implementation team contributes to increased rates of QI success and that, nurses alone may not hold enough authority within HCOs to effectively engage in QI in the current system (Locock et al., 2021).

The hierarchical nature of QI in HCOs also influences the way that healthcare professionals, including APNs, navigate their engagement with QI and attempts to move forward QI initiatives. In one study, APNs identified that all QI initiatives need to fit within the organization's current visions and goals to be considered and moved forward with the support of senior leadership (Schoales et al., 2018). To accomplish this, APNs acknowledged the need to use specific language to move forward QI initiatives that they wanted to prioritize, and that to be an effective change advocate as a clinician requires the use of "political language to make it stick" (Schoales et al., 2018, p. 106). Another participant described this skill as having "the words needed to have this issue or this initiative fit into the hospital big picture" (Schoales et al., 2018, p. 106). NPs working on a clinical-care focused QI project identified that they had to carefully navigate their language to be able to justify to the organization the value of their proposed QI project and the value of their role in relation to QI (O'Sullivan, 2022). They discussed how organizational "Key Performance Indicators" take precedence in HCOs over more subtle improvement measures such as improved competence in delivery of trauma informed care (O'Sullivan, 2022).

Along similar lines, there was acknowledgement that without recognition of the hierarchical structures in HCOs and high-level organizational priorities, moving QI initiatives forward becomes highly challenging. Consistently in the literature, measurable, quantitative clinical indicator data was identified to be a higher value priority over more qualitative data and indicators, such as patient experience (Ericson-Lindman & Strandberg, 2021; Locock et al., 2021; O'Sullivan, 2022; Schoales et al., 2018). Some participants suggested that any patient-facing change initiatives need to be justified to HCOs using metrics and evaluation methods that are reflective of HCO indexes of quality rather than clinical indexes of quality, meaning that clinically driven change efforts may not be recognized or validated by HCOs (Ericson-Lindman & Strandberg, 2021; O'Sullivan, 2022; Schoales et al., 2018). Parallel to this, participants in a study exploring perceptions on QI identified perceived lack of organizational support and organizational allocation of resources for patient-facing driven QI and change initiatives, furthering a lack of confidence for patient-facing staff to pursue change initiatives that are meaningful to them (Locock et al., 2021).

Emotional and psychological impacts of change

Themes surrounding the emotional and psychological impacts of change arose in the review of the literature, with many study participants identifying that organizational QI and change initiatives had negative impacts on them. Both change leaders, including nursing managers, and patient-facing staff identified that organizational change contributed to negative emotional and psychological effects (Knight, 1998; McMillan & Perron, 2013; Morrison & Jensen, 2022).

Themes surrounding loss of control and themes of uncertainty were identified among participants that described their experienced with organizational change. One participant

identified feeling the need to “keep [their] head down” as a coping mechanism to the negative impacts of change (Knight, 1998, p. 1291). Others nurses described becoming apathetic towards change and disconnected from the workplace as coping mechanisms for their experience with change (McMillan & Perron, 2020a). Loss of control and feelings of uncertainty were also described among change leaders, including nursing managers, who described feeling powerlessness with regards to organizational priorities, such as the prioritization of productivity above all other competing priorities, including staff retention (Morrison & Jensen, 2022). This sense of powerlessness contributed to feelings of frustration and stress among participants (Morrison & Jensen, 2022).

Issues surrounding workload and psychological impacts of rapid change in the workplace were discussed. The literature highlighted how participants described feelings of isolation, a lack of direction, abandonment, and stress following change initiatives (Knight, 1998; Morrison & Jensen, 2022). Another study explored how rapid change in healthcare organizations contributes to high levels of burnout among nurses (McMillan & Perron, 2020a). This study also described how rapid change results in the intensification of nursing work, which can contribute to negative impacts on patient care including missed care, which in turn can create issues of moral distress in nurses (McMillan & Perron, 2020a). Findings supporting the negative impacts of change on nursing workload were also supported in another study, where the change agents responsible for engaging in QI describe the way that change initiatives create a “work overload” that was not supported by the HCO (Ericson-Lindman & Strandberg, 2021). Participants described not having enough time allocated to engaging in their QI work and meeting their other responsibilities, contributing to burnout among change agents (Ericson-Lindman & Strandberg, 2021).

Mistrust in response to change and those responsible for change initiatives, including organizational leadership and direct clinical management, was also a theme that arose in the literature (Cakiroglu et al., 2022; Frilund et al., 2023). In one study, participants expressed mistrust in organizational change that resulted from perceptions of insufficient planning, poor collaboration with staff and staff involvement in change planning, and not having enough information with regards to the change planning process (Cakiroglu et al., 2022). Other nurses described mistrust relating to organizations' motives for change; participants detailed that they perceived organizations being motivated to engage in QI and organizational change for political reasons rather than for reasons relating to improved care or quality indicators (Frilund et al., 2023). This participant perspective is summarized well in the following statement: "there is an obvious risk that such a focus on efficiency and productivity may become guidelines for health care, potentially at the expense of the well-being of employees and users" (Frilund et al., 2023, p. 5430). Participants also expressed mistrust that they would be "cared for" and supported through the change process, some even expressing anxieties surrounding job security during periods of organizational change, contributing to poor emotional and psychological impacts (Frilund et al., 2023, p. 5429).

How Healthcare Organizations Benefit from QI

The literature also highlighted several positive experiences and benefits of QI in healthcare. Some of the more general benefits of QI that were discussed in the articles included that QI is a tool that can be used to accomplish a variety of positive system and organizational goals, including improving integrated and comprehensive care for patient benefit, increasing capacity and knowledge of healthcare professionals and improving transitions out of hospital, allowing for increased patient independence and comfort at home (Diaczun & Miller, 2023). QI

was also identified to be a tool that could be used in the movement towards EBP, a movement in healthcare where the goal is to translate the best available evidence into clinical practice (Steinskog et al., 2021). QI was also acknowledged as a positive tool to address advancements in healthcare technology, which helped to significantly advance patient outcomes and has transformed the way healthcare is delivered and organized in various settings (Frilund et al., 2023).

Several of the articles examined discussed the way in which specific quality improvement initiatives demonstrated benefits in their organizations. O'Sullivan (2022) reviewed that a QI project that saw the introduction of a mental health NP in an emergency department setting in Canada allowed for increased integration of the healthcare system between the mental health branch and medical branches, resulting in positive impacts on vulnerable patients. Similarly, Schoales et al. (2018) reviewed how CNS spearheaded QI initiatives resulted in better system integration and the establishment of better collaborations between healthcare partners which resulted in a new treatment pathway that allowed cancer patients in their community to receive treatments at home. One study highlighted how QI was utilized to reduce patient harm in a nursing home setting by implementing a project that specifically aimed to reduce falls in the home (Abrahamson et al., 2013). Magadze et al. (2022) reviewed how QI could be used as a tool to implement infection prevention measures in hospital settings in South Africa, where uptake of comprehensive infection prevention protocols remains low. They reviewed that by utilizing QI initiatives to implement these measures, they could achieve widespread improvements in care, not limited to reducing hospital acquired infection rates among patients, reducing workplace acquired infection rates among staff, reducing bed occupancy, reducing strain on antibiotics and

other medications in the hospital, reducing length of patient stay, reducing cost to the hospital and reducing patient harm and suffering (Magadze et al., 2022).

Some articles discussed the organizational and system-wide fiscal benefits of QI implementation. The literature identified that QI was often implemented out of systemic necessities for increased efficiency in the healthcare sector resulting from nursing and other healthcare professional shortages, funding limitations, and increased strain due to aging populations in many developed countries (Solbakken et al., 2020). For example, QI was used as means to increase efficiency and fiscal responsibility in Denmark, where due to politically negotiated demands to increase efficiency, they save an increase in efficiency of nearly 20% over 10 years in the early 2000s (Morrison & Jensen, 2022).

Summary

In this chapter, an overview of the literature review search strategy was provided. several themes were derived from the literature reviewed, presented through a discursive critical lens. These included an overview of the construction of the APN role in relation to QI, how nurses and nurse leaders are prepared (and not prepared) for QI, the exclusion of nursing leaders in QI planning, incongruencies in nursing and healthcare organizational values, nursing experiences with hierarchies in QI, the emotional and psychological impacts of change on the nursing workforce, and an overview of how HCOs benefit from organizational integration of QI.

Chapter 3: Theoretical Framework

In this chapter, theoretical underpinnings are conceptually presented and explored, providing a foundation in which the methodology is grounded an in which the results and discussion are presented in this thesis. First, Foucauldian Critical Theory is presented with respect to its historical and philosophical orientation. Next, key concepts that ground this thesis' critical analysis, specifically discourse, knowledge/power, and governmentality, are presented, reviewed, and conceptually clarified.

Introduction to Foucauldian Critical Theory

Critical theory is a broad intellectual tradition that originated in the fields of philosophy and social science, notably associated with the Frankfurt School in the mid-20th century. It encompasses various approaches and perspectives, but at its core, critical theory is concerned with analyzing and critiquing society, culture, and power structures (Hoy, 1994).

Frankfurt School critical theory aspires to be *self-reflective*, grounded in the way research is embedded in specific social and historical contexts, *interdisciplinary*, combining domains of sociology and philosophy, *materialist*, always ensuring that theory comes back to the social reality it represents, and *emancipatory*, remaining directed towards emancipatory action and social justice (Celikates & Flynn, 2023). Critical theorists seek to understand how social institutions, norms, and ideologies shape and influence individuals, often with a focus on issues related to power, inequality, and social justice. They explore the ways in which dominant ideologies maintain and reproduce social hierarchies, and often they aim to uncover hidden mechanisms of oppression (Rasmussen & Swindal, 2004).

Postmodernism emerged within critical theory largely vis-a-vis the work of French philosophers in the1970s. The term postmodern was first coined in a 1979 publication by Jean-

Francois Lyotard titled “The Postmodern Condition.” In this book, he defines postmodernism as an absolute rejection of grand narratives, or “metanarratives” which predominantly align with modernity (Lyotard, 1984). This represents a significant break from Frankfurt School and Marxist traditions which embrace overarching political themes of emancipation.

It is important to distinguish that postmodernism represented both a break and a continuation of the traditional critical thought grounded in the Frankfurt School of Critical Theory. Postmodernism remains grounded in an interdisciplinary approach to theory, combining social, political, economic sciences and philosophy to guide thinking (Best & Kellner, 1991a, p. 215). Postmodern theory continues with turning criticism towards instrument rationality, or means-end reasoning, which they consider a bureaucratic instrument of domination (Best & Kellner, 1991a, p. 215; Celikates & Flynn, 2023). It also remains critical of divisions and classifications within society (Best & Kellner, 1991a, p. 215). And while postmodernism rejects metanarratives surrounding grand societal emancipation, it does still embrace emancipatory methodologies and remains directed towards political action and practice (Best & Kellner, 1991a, p. 215). Where postmodern theory diverges from more classical thought in critical theory is the way in which postmodernists absolutely reject all grand narratives: “the historical ontology of ourselves must turn away from all projects that claim to be global or radical” (Foucault, 1984, p. 46). Postmodernism also moves towards a social philosophy which embraces multiple truths and incoherence over societal coherence (Aylesworth, 2015; Best, 1994, p. 29).

One of the most recognizable names in postmodern thought (albeit he rejected such labels) is French scholar Michael Foucault. Born in France in 1926, he studied at the renowned École Normale Supérieure before establishing a career in academia working in various Universities across Europe and France in the 1960s until gaining a permanent position as Professor of the

History of Systems of Thought at the College de France in 1969, where he worked until he passed away in 1984 at the young age of 57 (Best, 1994, pp. 26–27; Gutting & Oksala, 2022). Foucault's critical scholarship is often described as difficult to classify, nonetheless is closely associated with postmodern thought. Foucault himself rejected all labels associated with his scholarship, including postmodernism, instead describing his work in the following way: "my objective ... has been to create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 1982). Despite Foucault's insistence on turning away from labels, a look into his scholarship reveals his close ties to the philosophical school of postmodernist critical theory. Re-examining previous articulated arguments for what defines critical theory, specifically theory that is *self-reflective*, *interdisciplinary*, and *materialist,* Foucault's work is strongly aligned. An examination of Foucault's scholarship within genealogy reveals a multidisciplinary methodology that aims to uncover societal and historical contexts that inform taken-for-granted truths at different points in time (Best & Kellner, 1991b, pp. 49–50).

To see the ways in which Foucault's work breaks away from traditional critical theory and grounds itself in postmodernism thought, it is helpful to examine how Foucault's scholarship adopts the rejection of grand narratives and metanarratives (Best, 1994, pp. 29–30). Foucault's examination of the relationship between knowledge and power, which will be explored further in this chapter, aligns with postmodern thinking in the sense that he examines the way in which knowledge is not conceptualized as grand, universal truths but rather a tool used to in the subjugation of power in the population (Nola, 1994). And while Foucault rejects the grand themes of emancipation seen in modernist theory, his work is viewed as emancipatory in nature due to his commentary on oppressive discourses that exist in institutional bodies including

prisons and psychiatric hospitals, creating space for emancipatory action, which remains consistent with postmodern thinking (Moussa & Scapp, 1996, p. 93).

Foucault's contributions to social philosophy helped to significantly move forward the field of critical theory. These contributions can be examined through his research and publications. In 1961, Foucault published "History of Madness in the Classical Age," an examination of the tracings of mental illness and institutionalization over the course of history. In 1966 he published "The Order of Things" where he historically traces and analyses the changing nature of knowledge and ways of thinking of society over time. His work on the examination of knowledge is furthered in his 1975 publication "Discipline and Punish," where he provides commentary on modern prisons and examines the ways in which knowledge, power, and control, inseparably intersect with each other. In 1976, he publishes "The History of Sexuality," which can be seen as an extension of his examination of control, knowledge, and power through the lens of discourses on sexuality traced over time.

Having explored the historical context that grounds critical theory, postmodern thought, and particularly the scholarship of Michael Foucault, this author will now turn to the theoretical framework that guided this thesis' research. This research is grounded in the critical scholarship of Michael Foucault, more specifically, Foucault's theory and conceptualization of *discourse* and its relation to governmentality, knowledge, and power, from which the research methods and analysis of this thesis are derived. Each of these topics will now be examined further to provide conceptual clarification for the theoretical framework of this thesis.

Discourse

Creating a clear conceptual definition of discourse can be challenging as many scholars have adopted different definitions over time. For this thesis, this author draws from Michael

Foucault's definition of discourse: a structured way in which thinking, speaking, and relating to a topic are organized that both enable and constrain what we know about that topic (Cheek, 2004; McHoul & Grace, 1993, p. 37). When introducing the concept of *discourse* during a lecture, titled "The Order of Discourse," Foucault made the following statement: "in every society the production of discourse is at once controlled, selected, organized, and redistributed by a certain number of procedures whose role is to ward off its powers and dangers, to gain mastery over its chance events, to evade its ponderous, formidable materiality" (Foucault, 1981, p. 52). This statement reveals the way in which Foucault conceptualizes discursive systems in various facets of society. Close attention must be given to the word "production," as a closer examination of Foucault's conceptualization of discourse reveal the way in which the production, or control of discourse at any given time, is not controlled by any individual person, group, or institution, but rather a product of relational forces in society (McHoul & Grace, 1993, p. 54). Discourses are often assumed, or taken for granted, impacting the way that society and individuals see, think about, and relate to ideas, events, and phenomena (Cheek, 2004). They can be conceptualized as an examination of "the way the world is and has been for actual historical individuals," or "the real institutions of social life" (Miller, 1990, p. 116).

Discourse can embed itself or reveal itself in the speech and language mobilized in the societal context where the discourse is observed. In *The Order of Things*, Foucault describes the ways in which discourse is revealed through language:

> When this discourse becomes in turn an object of language, it is not questioned as if it were saying something without actually saying it, as if it were a language enclosed upon itself; one no longer attempts to uncover the great enigmatic statement that lies hidden beneath its signs; one asks how it functions: what representations it designates, what elements it cuts out and removes, how it analyses and composes, what play of substitutions enables it to accomplish its role of representation (Foucault, 1970, p. 88).

In this interpretation, Foucault suggests that through speech and language, discourse can be examined via attenuation to the content, absence of content, rules, and assumptions that are located within the speech and language of interest (Felluga, 2015). Discourse impacts the way we speak about things, the thoughts and ideas that are and are not acceptable in the way ideas are shared, and the implicit rules around the expression of thoughts, ideas, and language; in this way, per Foucault, "speech may be of little account, but the prohibitions surrounding it soon reveal" the ways in which discourse interweaves itself into language (Foucault, 2005, p. 316).

The way in which discourse is so thoroughly embedded in speech, social practice, imagery, art, and expression reinforces the argument that "discourses are a real social practice" (Keller, 2011, p. 49).

Multiple discourses can exist around individual topics, however not all discourses have the same level of authority or presence at any given point in time (Cheek, 2004). This creates inherent power imbalances between dominant, or widely accepted discourses, and subjugated or alternative discourses (Hook, 2001). Foucault, reflecting on his studies and examination of the history of mental illness and institutionalization, brought attention to the presence of alternative discourses. He described the expressions of the marginalized as "one whose discourse cannot have the same currency as others," highlighting the hierarchical nature of discourses within society (Foucault, 1981, p. 53). Alternative discourse, also coined "counter-discourse," can be interpreted as a way in which marginalized or counter-cultural voices can clear space to vocalize their desires, "begin to speak a language of their own making," and begin to "resist the power seeking to oppress them" (Moussa & Scapp, 1996, p. 89). An examination of discourse, counter-discourse, and hierarchies reveals the way in which discourse allows for the legitimization of

some forms of knowledge over others, and such, discourse becomes irrevocably linked to power (Hook, 2001).

Discourses are not fixed, but instead are fluid and susceptible to transformations over time (McHoul & Grace, 1993). The transformations of these discourses are tied to political practice, not in the sense of any individual political authority figure, but in the sense of greater political and societal landscapes that influence the meaning, emergence, insertion, and functioning of discourses in society (McHoul & Grace, 1993, p.54). Foucault, when describing the way in which discourse evolves over time, states that over history "a certain division was established, separating true discourse from false discourse: a new division because henceforth the true discourse is no longer precious and desirable, since it is no longer the one linked to the exercise of power" (Foucault, 1981, p. 218). Foucault describes the history and evolution of discourse over time as uneven, fragmented, with no clear path forward or backward; he describes how discourse develops and presents itself in society at uneven intervals and uneven development over time (Best & Kellner, 1991a).

Each discourse has its own history of emergence and history of transformations (Felluga, 2015). These emergences can be traced via examination of the rules, restrictions, rituals, and subjects that exist alongside the discourse and are subject to the discourse over time (Felluga, 2015). Foucault describes the tracing of discourse as it reveals itself in society via order in the following statement: "experience of order… its developments… in the mainstream of a culture such as ours: in what way, as one traces… language as it has been spoken, natural creatures as they have been perceived and grouped together, and exchanges as they have been practised; in what way, then, our culture has made manifest the existence of order" (Foucault, 1970, p. xxiii).

The transforming nature of discourses allows the discourse and its evolution to be traced through time. According to Foucault (1970), "our thought, the thought that bears the stamp of our age and our geography" (p. xvi), revealing the way in which he identifies understanding the thoughts, speech, language, of society over time as key to understanding the discourse of that epoch. The practice of historically tracing discourses via genealogical means can create an understanding of the power and political relations that enabled the conditions of the discourse to form and emerge over time (Mahon, 1993). This process of tracing and analyzing discourse can be accomplished via a structured methodology known as Foucauldian Discourse Analysis, or FDA (Cheek, 2000). To engage in FDA, the person must identify and bring to emergence the "dynamic and conflicting miscellany of discourse" that has taken place via a genealogy (Miller, 1990, p. 117). The genealogical practice of examining discourse has become one of the fundamental underpinnings of FDA, which will be explored further in the methodology section (Mahon, 1993).

Power and Knowledge

Foucault's conceptualization of knowledge and power form further theoretical underpinnings to ground this thesis' discourse analysis. Foucault defines power not as an entity held by individuals or governing bodies, but as relational forces within social bodies; per Foucault "power is not… one individual's domination over others or that of one group or class over others… Rather power must be analysed as something which circulates… It is never in anybody's hands" (Foucault, 1980, p. 98). Power is something that is "diffused through multiple social sites" via what are the accepted forms of knowledge in the social milieu (Best & Kellner, 1991a, p. 44). Power does not have a subject; it is not directed towards anything in particular,

rather it passes through networks where individuals are subject to the relational forces of power. In the words of Foucault:

> …[power] is never appropriated in the way that wealth or a commodity can be appropriated. Power functions. Power is exercised through networks, and individuals do not simply circulate in those networks; they are in a position to both submit to and exercise this power. They are never the inert or consenting targets of power; they are always its relays. In other words, power passes through individuals. It is not applied to them (Foucault, 2003, p. 29).

Foucault's conceptualization of knowledge and power can be studied closely and better understood via his writings in the *History of Sexuality*, where Foucault explores how the "deployment of sexuality" in society, inclusive of medical, social and political domains, over time resulted in the production of various perversions and categorizations of sex and sexuality, which then are disseminated in accordance with normalizing strategies of power (Best & Kellner, 1991a, p. 52). Power can carry through normalization processes, where understanding and behaviours are shaped and influenced via the power that exists everywhere in the social and political milieu. Aptly, "power is everywhere; not because it embraces everything, but because it comes from" (Foucault, 1978, p. 93).

Foucault sees knowledge as the disseminator of power, and as such views the concepts of power and knowledge as inseparably linked and fully entangled (McKinlay & Pezet, 2019; Mills, 2003). According to Foucault, power produces and legitimizes knowledge and produces what is considered to be truth or reality in society; simultaneously, knowledge legitimizes and reinforces power structures (McHoul & Grace, 1993, p. 59). Foucault's conceptualization of knowledge disregards claims of accuracy, objectivity, and what is true or false; instead, at its core, knowledge consists of the widely accepted views and perspectives of a group or society (Miller, 1990, p. 117). Knowledge is not internal, or something that belongs to any agent, but rather

knowledge acts externally on agents as they are subjected to the statements and regiments of knowledge.

The significance of the power/knowledge dyad cannot be understated, as it allows for the normalization and perpetuation of accepted forms of knowledge through educational, political, and other institutions, while simultaneously erasing alternative forms of knowledge (McHoul & Grace, 1993, p.64). Power enables society to "declare certain policies or practices as more effective than others" (McKinlay & Pezet, 2019, p. 209). Power acts simultaneously as an oppressive and a productive force; power operates to produce knowledge and constrains how that knowledge is produced and emerges (Best & Kellner, 1991a, p. 49).

Power "doesn't only weigh on us as a force that says no, but… it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault, 1980, p. 119). As per Foucault, the knowledge/power dyad is essential in the production and creation of new knowledge; without power, there is no knowledge creation and without knowledge, there is no power:

> We should not be content to say that power has a need for such-and-such a discovery, such-and-such a form of knowledge, but we should add that the exercise of power itself creates and causes to emerge new objects of knowledge and accumulates new bodies of information. … The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power. … It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power. (Foucault, 1980, p. 51-52).

The power/knowledge dyad is key to the social functions of discourse. Prominent, accepted discourses are established through power relations and legitimized via knowledge surrounding these discourses (Cheek, 2000). Knowledge enables specific practices within the context of that knowledge, resulting in actions that fit within the realm of the discourse at hand (Moussa & Scapp, 1996, p. 90). The relations of power that we see are "indissociable from a

discourse of truth, and they can neither be established nor function unless a true discourse is produced, accumulated, put into circulation, and set to work" (Foucault, 2003, p. 24).

Discourse is also central in the way that knowledge and power interact to produce and limit what we know. Prominent, accepted discourses are mobilized in ways that both enable and constrain what we know by both enabling and driving the creation of knowledge that reinforces the discourse while simultaneously de-legitimizing alternative forms of knowledge (McHoul & Grace, 1993, p. 33).

Forms of knowledge and truth are not static; they are dynamic and change over time in response to shifts in power and discourse in the social milieu. Present forms of knowledge, created by modern discourses, are temporary; with new inventions, new discourses, current forms of knowledge will be replaced and take on new forms and be accompanied by new sets of practices and new regimes of truth (Gaurav, 2021).

Because of the power wheeled by discourse and its inseparable relationship to knowledge, official discourses hold a strong level of authority and hold the power to over-inset this authority through the relations they enable and constrain (McHoul & Grace, 1993). What counts as "truth" is a product of discourse and power; "truth" is entirely contingent on current forms of the discourse (Hook, 2001, pp. 524–525). Current forms of knowledge and truth, along with the accompanying practices and actions that they create via discourse, are vehicles for and integral components of power (Best & Kellner, 1991a, p. 44). Foucault both recognizes and highlights how the significance of this relationship in the succinct statement: "discourse is not simply that which translates struggles or systems of domination, but the thing for which and by which there is struggle, discourse is the power which is to be seized" (Foucault, 1981, pp. 52–53).

Governmentality

The concept of governmentality expands on and draws from the concepts of discourse, knowledge, and power. Foucault introduced this concept through lectures delivered in 1978 but unfortunately left the concept unfinished in his final years (McKinlay & Pezet, 2019). Later scholars, including Mitchell Dean, went on to develop the concept of governmentality further, drawing from Foucault's initial work around its conceptualization (Dean, 2010).We can begin to understand Foucault's conceptualization of governmentality in the way that he examines power, as discussed in the previous section.

Drawing from Foucault's understandings of power and governance, we can conceptualize governmentality as a historically locatable way in which discourse, knowledge, and power intersect with specific strategies, technologies, and practices to act on individuals' own freedoms (Dean, 2010). Governmentality is not control of freedom through overt rule, rather it is a way of examining how we "conduct the conduct" through explicit and implicit practices including the proliferation of ideals, strategies, and knowledge that is socially or institutionally specific (Dean, 2010, p. 58; McKinlay & Pezet, 2019). Governmentality attempts to direct human behaviour by the setting of standards and norms to which actions can be compared and that individuals use to govern their own behavior and conduct (Dean, 2010). This can be accomplished by employing strategies to frame various problems in such a way that they become understandable and enable a certain degree of control over thoughts and actions (Glenn, 2019, p. 26).

Because of the power wheeled by discourse and its inseparable relationship to knowledge, official discourses hold a strong level of authority and hold the power to over-inset this authority through the relations they enable and constrain (McHoul & Grace, 1993). Foucault

highlights how there are many possible subjects of governmentality, including society, community, family, or individuals, and that these subjects can all be governed and have their behavior regulated via strategy and tactics (Foucault, 1996, p. 410).

The standards, norms, technologies, and other methods used to achieve a state of governing are embedded into organizations' practices, strategies, and structures, and also embedded into the guiding social micro-practices of individuals in their decision making and conceptualizations of knowledge (Dean, 2010; McKinlay & Pezet, 2019). Thus, the technologies of governmentality can be conceptualized as both practices of individualization, where the individual is the subject of governing practices, and practices of institutionalization, where larger organizations or social structures are the subject of governance (Lemke, 2015, p. 30).

Through governmentality, discourses, knowledge, technologies, and practices are weaved to construct the social realities of individuals in different settings, and guide the understanding of what is acceptable practice versus non-acceptable practice (Dean, 2010). Discourse creates a state of "strategic relations that constitute a collective will that did not exist beforehand" (Lemke, 2015, p. 32). Via discourse and discursive practices, a distinct inside the state versus outside the state situation is created in which technologies of governmentality can act (Lemke, 2015, p. 32). Governance rests on "modes of thinking and knowing" which enable the technologies and practices of governmentality to be effectively enacted (Perron & Rudge, 2015, p. 57).

Despite this, an essential component to the conceptualization of governmentality is the concept of subjectivity, in which the free subject is acknowledged as having authority and freedom over their own actions, and has the freedom to resist the social structures of governmentality that are in place to regulate their conduct (Dean, 2010). Thus, free subjects are

able to engage in resistance of governmentality and discourse by presenting alternatives to current practices (Dean, 2010). The use of speech and language, in the form of criticizing governing structures, is identified within a governmentality framework as means of challenging and overturning repressive governance (Moussa & Scapp, 1996, p. 93).

Under the umbrella of governmentality, drawing in particular from *History of Sexuality,* Foucault conceptualized a form of governance that relates specifically to governance and discourse on human life and health: biopolitics and biopower. Foucault examines the governing strategies used to achieve "power over life" (Foucault, 1978, p. 139). Specifically, he analyses the ways in which power is exerted on human health via knowledge and regulation of the "body as a machine" and the body "serving as the basis of the biological processes" (Foucault, 1978, p. 139). The ways in which we mobilize to supervise, categorize, and enable the utilize of the human body and its biological processes are conceptualized as forms of regulatory controls, which Foucault calls "a bio-politics of the population" (Foucault, 1978, p. 139).

Biopower is the employment of governmentality to organize, monitor, govern, and optimize human life (Perron & Rudge, 2015, p. 58). Biopolitics enables us to examine processes of life and in turn govern individuals and groups utilizing governance technologies including correction, exclusion, normalization, disciplining, and specific to the realm of health activities, therapeutics, and optimization (Lemke, 2015, p. 5). Under biopower, discourses are employed to engage in various healthcare related activities, including the management of health conditions and the management of healthcare providers and associated works structures. As such, biopower can be used to govern APN roles and role functions, which include engagement with QI driven

initiatives, making this a highly relevant theoretical grounding to explore the chosen research topic.

Governmentality is strongly tied to the promotion of official forms of knowledge and discourse. Through its complex, interwoven implicit and explicit practices, governmentality can construct what is understood as "expertise" of a certain topic, give authority to knowledge experts around specific topics and thus act to delegitimize alternative forms of knowledge and discourse that may challenge or be opposed to this "expertise" (McKinlay & Pezet, 2019). In the context of this research, this theoretical framing offers an opportunity to examine the positionality of APNs in QI to answer the research question: what are the forms of subjugated knowledge and discourse that emerge in QI-centered spaces in healthcare organizations? This theoretical foundation allows an examination of what lies beneath existing, taken for granted assumptions and the dominant discourses that drive QI in healthcare.

Summary

Foucault's conceptualization of discourse, knowledge, and power provide the foundational theory necessary to ground the methodology of this thesis. As has been reviewed in this chapter, discourse, or the ways in which a person or group thinks about, speaks about, and relates to a topic, is inseparably linked to the concepts of knowledge and power. Discourse enables and constrains our forms of knowledge, simultaneously legitimizing widely accepted, mainstream ways of thinking while de-legitimizing alternative forms of knowledge. Concurrently, emerging forms of knowledge can influence, shape, and transform discourse at any given period. This bilateral relationship between knowledge and discourse enables discourse to wield tremendous power, as discourse influences what thoughts, behaviors, and forms of knowledge are desirable and acceptable within an individual or a group. The power that

discourse possesses can be wielded via strategies, technologies, and practices, knowingly or unknowingly, to regulate the thoughts, speech, behaviors, actions, and restrict the freedoms of individuals and groups via processes collectively known as governmentality. Governmentality and its associated discourses are contingent on historical context, and as such, are historically locatable and can be historically traced via a discourse analysis, thus allowing us to uncover the social contexts from which discourses are formed and the evolution of these discourses over time. In the next chapter of this thesis, the structured methodology for undertaking a governmentality-founded FDA, which was utilized in this thesis to explore discourses on quality improvement in healthcare via the lens of APNs, will be reviewed in detail.

Chapter 4: Methodology

Dean's Governmentality Analytic (Dean, 2010) was selected to ground this thesis' methodology. This analytic methodology is reviewed in detail in this chapter. To accomplish a fulsome review of the thesis' methodology, several sections are explored in this chapter. First, the author introduces the concept of Foucauldian Discourse Analyses (FDA) and an overview of Deans' Governmentality Analytic, a specific type of FDA that was selected to guide the analysis of this study's data. Next, genealogy, an FDA strategy used to historically trace the emergence and transformation of discourse over time, is presented; a description of how genealogy was used to uncover and select this study's key historical documents is provided. Next, the author reviews ethical considerations of this study. An overview of the inclusion/exclusion criteria for study participants and a summary of the recruitment strategies used to engage study participants is described. The author then provides a description of the participants who engaged in this study. Next, detailed instructions for how Dean's governmentality analytic was used in the analysis of participant and historical document is reviewed. Lastly, the author provides an overview of the means of ensuring trustworthiness in this thesis' research process.

Note of acknowledgement: in the proposal development phase of this thesis, this author had difficulties identifying a methodology that well suited the research aim. Many methods used in the completion of Foucauldian discourse analyses (FDA) do not incorporate experiential forms of knowledge in the form of participant interviews in their methodological approaches and rather rely exclusively on document analysis. In a search for an approach that fit both the research aim, questions, and theoretical underpinnings of this thesis, this author came across a PhD dissertation by Dr. Rene Wong in which discourses of "good diabetes care" were explored using an FDA methodology that incorporated both document analysis and participant interview data as a means

of uncovering discourse (Wong, 2020). This dissertation is the source from which this author drew inspiration for the methodology of this thesis and adapted it accordingly to suit the specific aims of this research.

Foucauldian Discourse Analysis

Foucauldian Discourse Analysis (FDA) aims to uncover and expose taken for granted information that is generally accepted as truth within specific social bodies, to understand the historical influences and practices that led to this information becoming accepted as truth, and to offer an alternative to the dominant discourse (Cheek & Porter, 1997). There is no prescriptive methodology for the completion of a FDA as Foucault himself did not identify any set way to go about a discourse analysis; his own methodology varied significantly throughout his career (Cheek & Porter, 1997). Per Foucault, "discourse… is so complex a reality that we not only can, but should, approach it at different levels with different methods" (Foucault, 1981, p. 72).

The evolution of Foucault's methodologies for undertaking discourse analyses can be tracked via the evolution of his works. In Foucault's 1969 publication, *The Archaeology of Knowledge*, he historically traces the modern foundations of knowledge and examines how knowledge is organized via a methodology known as *archaeology* (Yates & Hiles, 2010). Foucault describes archaeological methodologies as a means of uncovering the rules and division which govern language, knowledge, and thought and how these rules change throughout history (Garland, 2014). Foucault is not interested in assessing the veracity of discourses as they occur throughout history, rather is interested in the historically traceable rules that gave validity, power, and meaning to discourses throughout different epochs (Sampath, 1995). A researcher utilizing archaeology aims to uncover the discontinuities, or abrupt historical transformations,

which emerge over time and how these discontinuities create shifts in the traceable discourse, knowledge, and thought of those time periods (Garland, 2014).

Foucault later expressed a shift in his conceptualization of discourse and how to historically trace discourse, turning away from previous archaeological methodologies towards new methodologies that he felt could address some of the limitations he felt existed under an archeology framework (Garland, 2014). Specifically, we can see this shift in methodological approach to discourse analysis leading up to the research and publication of *Discipline and Punish* in 1977 (Garland, 2014). Foucault identified that archaeology failed to account for and consider the social aspects of discourse, specifically how discourse emerges from and acts within social milieus; he suggested that archaeology failed to capture the essential social aspects of discourse (Garland, 2014; Yates & Hiles, 2010). He went on to abandon previous archaeological methodologies for discourse analyses and instead turned to *genealogy*. Genealogy aims to trace the gradual, evolving emergences of discourses over time via power struggles relating to the use, meaning, and role of discourse, where a discourse proceeds to emerge as victorious over others (Garland, 2014; Yates & Hiles, 2010). Per Foucault, "genealogy … seeks to reestablish the various systems of subjection: not the anticipatory power of meaning but the hazardous play of dominations" (Foucault, 1984, p. 84). Genealogy explores how present-day knowledge, discourse, and social practices are a result of the historical evolution of discourse, in which evolution occurs gradually via power and knowledge relations rather than in a discontinuous fashion that was previously described under archaeology (Sampath, 1995). Genealogy aims to reveal the historical conditions and evolutions that allow discourse to hold legitimacy and practice in current contexts (Garland, 2014).

Grounding this research in the Foucauldian lens of power and discourse allowed this author to examine the ways in which healthcare workers, or in the case of this research, APNs, are both subjected to, and exert power via discourses surrounding QI in healthcare and also act as vehicles in which discourses surrounding QI in HCOs are transmitted and consolidated. Using a Foucauldian discourse framework where multiple alternative and subjugated discourses around a topic exist at any point in time, the author also had the opportunity to uncover alternative discourses surrounding QI in HCOs and how different subjects may define *quality* in healthcare in ways that may challenge prominent, widely accepted discourses that surround *quality* at this time. Using a Foucauldian lens, this author was able to uncover the behaviors and comportment of individual APNs and the ways in which they both conform to and resist the widely accepted discourses around QI in HCOs.

To accomplish the thesis' research aims of identifying the dominant discourses in HCO QI, exploring how these discourses impact the experiences of APNs, and identifying the subjugated discourses that exist in healthcare QI, this author utilized a FDA-grounded methodology that allowed for the exploration of discourse, power, and knowledge via the lens of governmentality. This was accomplished using Dean's (2010) framework for governmentality-founded discourse analysis, which helped examine how APNs were governed and the way in which they govern themselves in their QI work. Dean's (2010) framework also supported the exploration of alternative discourses and potential acts of complacency or resistance to governmentality practices that systematically support the current status quo around HCO QI. Per Dean, "an analytics of government takes as its central concern *how* we govern" (Dean, 2010, p. 33). Therefore, a governmentality analysis places a high degree of importance on answering *how* questions: how have current forms of knowledge come to be constructed, how is this knowledge

translated into practice and behaviors in the social milieu, and how to the conditions in which regimes of knowledge and power emerge, operate, and transform (Dean, 2010).

Utilizing a governmentality lens, the analytical process allowed for the exploration of the forms of knowledge and technologies mobilized to regulate conduct, and the conditions in which "regimes of practice" are developed, transformed, and sustained (Rose, 1993). A governmentality lens allowed the author to concentrate on the relationship between strategies of governing, the technologies of the self and how individuals self-regulate behavior, and the strategies through which individuals are transformed via discourse (Rose, 1993). It also allowed for the examination of the ways in which individuals, in their subjectivities, may engage in forms of resistance to widely-accepted discourses and governing techniques used to uphold them (Rose, 1993).

Genealogy

The first step of Dean's governmentality analytic framework comprises of a genealogy of healthcare QI documents. Genealogical analysis is a methodological approach to discourse analysis developed by Michael Foucault in the 1970s which can be used to uncover the "history of the present," allowing researchers to deconstruct the historical and political influences that have formed current discourses (Foucault, 1979, p. 31; Mahon, 1993; Roberts, 2017). By performing a historical analysis of the discourses surrounding *healthcare organization quality improvement,* the widely accepted truths, knowledge, and associated power surrounding HCO QI could be broken down to trace a lineage of power, knowledge and politics that influenced the formation of the present state of discourse. Pezet (2019) articulates the result of a FDA-influenced genealogy in the following statement: "truth moves from being universal and timeless

to local and temporally specific, a fiction verifiable through historically specific regimes of power and knowing" (p.209).

To accomplish this genealogical analysis, key documents were selected that outline QI frameworks widely utilized in healthcare organizations. These documents were traced back to the initial emergence of quality improvement in healthcare, and utilizing Foucault's concept of archaeology probes, were analyzed with the intention of exploring the various factors and influences that shaped the emergence of things that otherwise may appear to be "natural," over time (Foucault, 1972). Consistent with genealogical methodology, the author systematically sought out documents that aimed to highlight the historical, political, and social influences as well as key turning points that may have helped to form the current discourses surrounding healthcare QI.

To achieve a genealogical analysis examining QI in healthcare, documents exploring *Lean* methodologies in healthcare were selected and historically traced. Lean is a set of QI methodologies originating from post-World War Two Japan in the Toyota Production System (Pyzdek, 2021, p. 3). Lean methodologies broadly focus on waste reduction as a means of achieving QI (Pyzdek, 2021). Lean methodologies have been adapted to be utilized as tools for the guidance of QI in HCOs and are widely used across North American healthcare settings. The Institute for Healthcare Improvement, an organization with a mandate to guide and further QI in HCOs globally, has validated Lean as effective tools for the guidance and implementation of QI projects in HCOs (Scoville & Little, 2014). As such, "Comparing Lean and quality improvement" (2014), an IHI publication guiding the application of Lean in healthcare improvement was selected as the starting point for the genealogical analysis from which other documents were historically traced. The genealogical process of historical document

identification for all other documents used in this analysis and rationale for the selection of these documents will be discussed in detail later in this chapter.

Scholars examining governmentality have critiqued traditional FDA's over-reliance on document analysis, suggesting that it allows for an analysis of content from the lens of the authoritarian structures while neglecting the subjective experience and perspective at the micro-social level of those subjected to power structures (Kerr, 1999). Given that the purpose of genealogies is to probe, uncover, and explore discourses and their impacts on the subjectivities of individuals within the social milieu, exclusion of subjective data introduces the risk of not gaining full depth of understanding of these discourses. Therefore the use of interviews was included to provide a tableau for the analysis of discourse at a social, micro-level, by providing an opportunity for participants to relay their experiences and point of view (Polit & Beck, 2021, p. 514). As this author aimed to explore dominant and subjugated discourses surrounding HCO QI, interviews were conducted with a select group of APNs, who provided a unique lens and perspective to how QI discourses emerge in HCOs and how these discourses impacts their nursing work. The characteristics of the participant sample will later be described in the results chapter of this thesis. The interviews with the APNs were then analyzed in parallel to formal QI documents using the analytic steps process which will be outlined later in this chapter.

Selection of Historical documents

A total of 7 historical documents were selected for genealogical analysis. A list of the historical documents, including author details and dates of publication, can be found in Table I below.

Table I: Historical Document Details

Document Name	Document Type	Author Details	Year Published
Evaluating the quality of medical care	Journal article	A. Donabedian	1966
Curing Health Care	Book	D. Berwick; A.B. Godfrey; J. Roessner	1990
Crossing the Quality Chasm	Book	Institute of Medicine	2001
The Breakthrough series	IHI white paper	Institute for Healthcare Improvement	2003
Saving 100 000 lives in US hospitals	Journal article	McCannon et al.	2006
Comparing Lean and quality improvement	IHI white paper	Institute for Healthcare Improvement	2014
Quality improvement plan guidance document 2025/2026	Healthcare organization instruction document	Ontario Health	2024

As discussed earlier in this chapter, completing a genealogy involves historically tracing the emergence of a specific concept with a goal of uncovering the evolution of the knowledge, thoughts, and behaviors that surround that concept over time. For this research, *Lean in healthcare* was selected as the starting point for genealogic tracing of QI in healthcare. Lean was selected because Lean tools, including value-stream mapping, increasingly guide large-scale quality improvement initiatives in healthcare organizations; literature exploring QI in healthcare frequently cites Lean in their methodologies (Fine et al., 2009). Given these ties between Lean-informed QI and the healthcare sector, *Lean in healthcare* was selected as a starting point to which discourses around HCO QI could be explored.

Using this as a starting point, a search for "Lean quality improvement healthcare" was performed on Google search engine, as the goal of this genealogy was to uncover documents and information that is open, easily accessible, and available to anyone who may encounter or engage with the subject matter. The 2014 IHI White Paper, Titled "Comparing Lean and quality improvement," was identified and selected as the starting point for historical tracing (Scoville & Little, 2014). The IHI represents an established body in the field of HCO QI advocacy, as previously established in the introduction of this thesis, and thus content from the IHI represents a good starting point for the examination of how discourse around HCO QI functions. This document outlined the history of Lean, theoretical foundations that guide Lean principles and how Lean has been utilized to guide QI in healthcare. It then goes on to compare Lean to IHI's own QI framework.

While reading through "Comparing Lean and quality improvement" references to other authors or documents relating to HCO QI that appeared in the document were noted, thus allowing for historical tracing to occur. By doing so, the author identified three further historical documents: the 1990 book titled *Curing Health Care,* an additional 2003 IHI White Paper titled "The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement," and the IHI's 2004 "100 000 lives campaign."

"The Breakthrough Series…" is a document that reviews how the IHI's QI framework was developed, the theory and history that grounds the framework, the dissemination of the framework that had taken place at the time of publication and its plans for rapid expansion of the framework across HCOs globally. Published in 2003, it allowed for the analysis and onlook of the state of knowledge and governance of HCO QI as it existed more than 20 years ago.

Curing Health Care, published in 1990, is largely considered a seminal publication of healthcare QI. *Curing Health Care* put forward recommendations for integrating formal QI frameworks and methodologies previously used in business and manufacturing sectors to the improvement of healthcare. The book identifies ways in which healthcare was deemed to be deficient at the time of publication and suggested that importing manufacturing-based QI methodologies to healthcare could help address these deficiencies. The author selected chapter 1, titled "Symptoms of stress in the health care system" for analysis in this research.

The "100 000 lives campaign" examined the post-implementation of a national, large-scale QI project. This document allowed for the author to access the language used in reflections on and evaluations of QI implementation.

In this author's attempts to locate an online copy of *Curing Health Care,* a review of the book was located, in which the reviewer referenced a second seminal book in healthcare QI published in 2000 titled *Crossing the Quality Chasm.* This book addresses the rapidly changing nature of the healthcare system and makes additional calls to "bridge the gap" between the current state and the authors' ideal state of quality healthcare (Institute of Medicine, 2001). This author selected the executive summary of the book as a historical document that could provide insight into the state of healthcare QI a full decade following the initial calls for formal HCO QI action outlined in *Curing Health Care*.

While reading *Curing Health Care*, significant references to the 1966 paper titled "Evaluating the quality of medical care" were made. The authors described how Donabedian was the first to make a formal attempt at defining quality in healthcare and critiquing QI evaluation methods. Given this work is largely recognized as the first formal attempt at appraising quality

and quality evaluation, it was selected as the starting point from which discourses around HCO QI would be traced in the analysis.

Finally, given the geographical specificity of this research, identifying a document that captures the local context was important. For this reason, this author turned to Ontario Health, an Ontario crown agency with a mandate to "connect, coordinate, and modernize our province's health care system" (Ontario Health, 2025). When searching for "Ontario Health quality improvement" in Google's search engine, this author was able to locate Ontario Health's 2025/2026 "Quality improvement plan guidance document," which outlines the mandatory quality improvement plans (or QIPs) that all HCOs in the province of Ontario must submit to Ontario Health annually.

All seven of these documents were selected and analyzed using Dean's governmentality analysis framework, allowing the author to engage in discourse analysis via analysis of historical texts in conjunction with interview transcripts.

Ethical considerations and participant data management

Research Ethics Board (REB) approval for this thesis research was obtained through the University of Ottawa on April 29th, 2024. This certificate allowed for participant data collection to be completed over a period of one year, ending April 28th, 2025, conditional on several ethical provisions being in place, which are outlined as follows.

Data was collected via virtual semi-structured interviews on Microsoft Teams, conducted by this thesis' author, allowing participants to respond in a narrative, descriptive manner, thus being able to relay their experiences with the subject matter (Polit & Beck, 2021, p. 282). The interview guide (Appendix C) was designed with questions that aim to gain an understanding of

the professional and work-life experiences of CNSs as they relate to quality improvement initiatives in hospital settings. Note that the interview guide was meant to act as just that - a guide, rather than a script, for the author to utilize to capture data that answers the research questions directly, but to also allow research participants the freedom to fully share their experiences in a non-inhibited way that does not limit their capacity to share their knowledge and experiences. Diverse interviewing techniques, including introductory open-ended questions, probing or clarifying sentences, and use of silence were utilized during the interviews to encourage open dialogue and sharing of subjective experiences (Adams, 2015).

The author of this thesis utilized Microsoft Teams transcription software to aid in transcription. However, this author also performed manual transcription of the interviews for the purpose of correcting errors and to allow for strong immersion in the data. During the transcription process, the names of the participants were removed and replaced by numerical codes. Additionally, names of the hospitals or other potentially identifying organizational information were also removed from transcription and replaced by codes to protect the research participants from being identified. A separate password-locked document was kept, organizing the hospital code names by important organizational details (size, type of hospital, rural vs urban) so that this information could be later referenced. This document did not link workplace characteristic to participant codes or organization codes. This document, the interview recordings, and all transcription records were all stored in password protected electronic files on the author's personal laptop, which was stored in the author's locked home office. The author was the only person to have access to raw data which included participants' identifying information; all original transcripts with personal information redacted were provided in full to

the thesis supervisor; the thesis advisory committee had access to a select sample of quotes and aggregate data which was selected to highlight the results of the analysis.

Given that paper consent forms were not utilized as all communication was virtual in nature, the author obtained informed verbal consent from all participants after reviewing the risks and benefits of the research to participants and prior to commencing the interviews; this informed verbal consent is reflected in the recorded interview transcripts. Original interview audio and video recordings were kept confidential and remained password protected, only accessed by the author for the purposes of transcription. The names of participants as well as the names of hospitals and other identifying information were removed during the transcription process and replaced by codes. Any and all dissemination of data in the form of presentations, webinars or written materials (publications, conference papers, etc.) only include assigned numeric codes and no identifying information (name of employee, name of any colleagues, city, any scenarios that would identify participant or their site of employment) appear in dissemination products. The author was and continues to be responsible for conserving the data in line with best practices in data conservation as they evolve, and as stipulated by the University of Ottawa's REB. The video and audio data were deleted immediately following transcription of the interviews. Data disposal was done through secure deletion processes. Transcripts, researcher notes, and analysis will be stored indefinitely.

Inclusion and exclusion criteria

The including criteria for this research were as follows: any Registered Nurse who a) self-identifies as a Clinical Nurse Specialist and who engages in quality improvement work in their scope of practice AND b) who has worked as a CNS in an Ontario hospital setting for at least one year AND c) who are able to comfortably relay their experience in English. Any CNSs

who in addition to quality improvement roles/responsibilities holds a position in hospital senior management/leadership will be excluded. Examples of hospital upper/senior management include (but are not limited to) roles such as Chief Nursing Executive, Director of QI, Director of Professional Practice.

Several considerations were held when deciding inclusion and exclusion criterion. CNSs were selected as the APNs of choice because, as previously discussed, while NPs are also considered to be APNs their professional duties are often mostly or exclusively related to clinical care, which may limit their abilities to effectively relay experiences relating to QI in HCOs. Hospital settings were selected for this research as hospitals are larger HCOs that are likely to have structured QI departments and processes integrated into their organizational structures. CNSs in a position of senior management/leadership were excluded as their mandates and responsibilities relating to QI are more directorial than the responsibilities of those who are tasked with engaging in and implementing QI into their daily workloads; this directorial lens, while unique, is inherently different than the governmentality-focused lens the author sought to explore in this thesis' research and the author and thesis committee felt that inclusion of these groups could cloud the data.

Recruitment

Purposive sampling was utilized in this research, as it allowed the author to select participants who have exposure to the phenomenon of interest (Polit & Beck, 2021, p. 265). A recruitment poster (Appendix D) that clearly and concisely stated the goal of the research, inclusion criteria, as well as anticipated time commitments was developed. Recruitment posters were distributed via social media, professional and social networks of the author and the members of the author's thesis committee, and relevant professional network organizations.

Recruitment poster distribution comprised of circulating the recruitment poster in APN and CNS interest groups on Facebook and LinkedIn, sharing the poster on the author's personal social media pages (LinkedIn, Facebook, Instagram) and emailing the poster to individuals in the author and thesis committee's social and professional networks with the expressed request to share the poster with potential participants. The author also attempted to engage in snowball recruitment when initial participants were recruited and participated in the study, whereas the author requested that the participants voluntarily share the recruitment poster with potential participants within their own social and professional networks.

Individuals who were interested in participating were asked to contact the author via email (as noted on the recruitment poster), at which time the author confirmed inclusion criteria was met. Once confirmed, an interview was arranged at a date and time that was convenient for the participant. Interviews were conducted virtually (MS Teams). Due to the limitations of both the timeline and the budget of this thesis, and to broaden the geographical scope of potential participants, in-person interviews were not conducted.

Consent forms that reviewed the research's purpose, participation requirements, ethical and confidentiality measures were sent to potential participants via email for review. Consent was sought prior to scheduling interviews and verbally reviewed with the participant before each interview commenced. Interviews were conducted by the author of the thesis and recorded using MS Teams' voice and video recording function. It was expected that interviews would last 30-60 minutes; in reality, the interviews were between 52-88 minutes in duration. Even though some interviews went over the expected time range, all participants were given ten- and five-minute warnings to allow them to conclude the interviews or continue if they wished. These recordings were later used for transcription.

The sample size was not pre-determined but was rather to be decided upon by the author and thesis committee based on the point at which richness in the data supported a substantive answering of the research questions. The author initially estimated that the sample size would be 8-10 individuals to fit the data needs of this research. Due to recruitment challenges, which will be discussed in depth in the discussion section of this thesis, only 7 interviews were conducted. Despite this, the author and thesis committee agreed that due to the richness and quality of data obtained in the 7 interviews, the research questions were able to be answered in a substantive manner.

Overview of participant interviews

A total of 7 participants engaged in one-on-one interviews between July to October of 2024, at which time all recruitment efforts were exhausted, and the author ceased to collect further interview data.

Participant characteristics presented with significant diversity in terms of educational and professional backgrounds. All participants completed their undergraduate nursing degrees at Canadian universities. Participants completed their Master's degrees at Universities in both Canada (n=5) and the USA (n=2). The nature of the Master's degrees varied from participant to participant, with three completing thesis-stream nursing degrees, and four completing course-based degrees, one of which focused on nursing education, and three of which were generalized nursing streams. All participants completed a Master's of Nursing. Some participants completed their Master's education prior to working in CNS roles (n=5), whereas others began working in CNS roles prior to the completion of their Master's (n=2). Those that worked in CNS roles prior to the completion of their Master's degrees identified that Master's completion was a condition for ongoing employment in their CNS role. The working experience of the participants varied

significantly as well, with participants ranging from 9-35 years of working experience as Registered Nurses in various capacities.

The nature of CNS roles differed from participant to participant. Some participants identified that their roles were more oriented towards clinical assessment and provision of clinical expertise; more specifically, two participants identified that most of their role was oriented towards the provision of direct clinical care and that they engaged in other spheres of the CNS role only when they had capacity to do so. One participant identified that staff education was their primary role mandate; their leadership activities centered around staff education initiatives, and they did not provide any direct patient or client care. Others identified that system capacity building and QI was their main mandate; two participants described working primarily on system improvement initiatives, with one also participating in some direct clinical care while the other did not engage in direct care capacities in their role. Two participants described roles in which they engaged equally in all pillars of the CNS role and had responsibilities that varied between clinical care, education, leadership, system improvement, and research. Two of the participants worked in CNS roles that were non-unionized leadership roles, whereas the others worked in roles that were unionized.

Discourse Analysis using Dean's analytic framework

To extract data from interviews and historical documents, Dean's (2010) analytic framework was utilized. This framework aims to examine how "taken-for-granted ways of doing things and how we think about and question them are not entirely self-evident or necessary" (Dean, 2010, p. 31). Keeping consistent with traditional FDAs, Dean's analytic framework does not concern itself with assessing the validity or veracity of the discourses used in governing,

rather it looks to explore the thoughts, strategies, and techniques that govern human conduct and shape individual social reality. This framework follows the steps that are outlined below.

Step one is problematization. Problematization involves "calling into question" some aspects of governing in specific regimes of power (Dean, 2010, p.38). To govern, conduct must first be shaped as a problem in which techniques of governance, or regimes of practice, are deployed to address the problem or "conduct the conduct." Problematizations occur with a high degree of specificity, occurring at specific dates, places, locales, and institutions (Dean, 2010). Problematization allows researchers to shine light on the very specific contexts in which governance is called in to "conduct the conduct" and to effectively engage in an analysis of these contexts (Dean, 2010, p. 38).

Problematization focuses on answering the "how" questions. It involves examining how the "governors," or authorities, and "the governed" conduct themselves (Dean, 2010, p.38). It involves asking questions that reveal how governing is conducted in specific contexts and how the governed conduct themselves when subjected to this power. Problematization highlights the ways in which governmentality, or the strategies and technologies used to empower individuals to self-regulate and engage in subjectivities, can be used as tools to secure the goals of government.

In this thesis' research, the problematization of "quality improvement in healthcare organizations" was completed to examine the "conduct of conduct" of QI in HCOs, specifically, who governs QI in HCOs, what techniques, language, methods are used to govern QI in HCOs, and how healthcare workers, particularly APNs, respond and conduct themselves in response to the QI HCO governing techniques that are deployed (Dean, 2010, p. 38). The problematization

of "quality improvement in healthcare organizations" will be reviewed in the results section of this report.

Step two is interpretive analysis. Dean (2010) provides a methodology that allows practices of governing to be uncovered and understood via the analysis of language and texts (in the case of this thesis, formal documents and interview transcripts). This analysis was done through examination of Dean's (2010) four pillars of governmentality analytic: visibility, episteme, techne, and identity. Each are described below.

Visibility concerns examining the ways in which regimes of power exert their influence through making things visible and by introducing elements that make it possible to "picture" the different elements of government (Dean, 2010, p.41). Visibility includes the physical tools, charts, and visual aids that are used to establish an understanding of what constitutes obedience or correctness within governance (Dean, 2010). Questions that were asked to uncover this pillar include: how is this discourse made visible? What is illuminated by this discourse and what is obscured? Where are these discourses located?

Episteme aims to examine the forms of knowledge, thought, content, and strategies that are used in the practice of governing (Dean, 2010, p. 42-43). Episteme makes up the connection between thought and governance, and how forms of knowledge are used to achieve various objectives of governance (Dean, 2010). Questions that were asked to uncover this pillar include: what forms of knowledge and expertise form current discourses around QI in HCOs? What forms of knowledge and thoughts define how QI work in HCOs is or should be carried out?

Techne aims to uncover the means, procedures, instruments, in which the governing agents carry out discourse (Dean, 2010, p. 42). Techne can be conceptualized as the various

"technologies of the government," or the ways in which governance limits what can or cannot be done in a given milieu (Dean, 2010, p. 42). Questions that were asked to uncover this pillar include: what are the mechanisms through which QI in HCOs is achieved? How is practice in QI regulated? How are truths that form discourse in HCO QI established and validated? Which organizational agents are key in achieving QI in HCOs and how are they discursively constructed?

Identity aims to understand the "individual and collective identity through which governing operates" and how governing forms and transforms identities that discourse act on (Dean, 2010, p. 43). The identity branch explores not how governance determines the subjectivity of individuals, rather how it elicits, facilitates, and fosters certain ideal qualities, behaviors and attributes (Dean, 2010). Some of the questions that the author asked to uncover this pillar include: how do HCO QI discourses influence how we think about healthcare workers, including APNs and other QI professionals? How are identities related to HCO QI enabled? Are these identities resisted in any way, and if so, what are the consequences? What forms of conduct are expected of these "identities" in HCO QI? How are identities in HCO QI formed and maintained?

The analysis of the interview transcripts and formal documents took place in three phases, described as follows:

1. Literal reading of the texts for content and context where texts were read and catalogued in a descriptive manner (for formal documents, the type of document, intended audience, source, date produced; for interviews, role of APN within HCO, type of HCO setting they work in). This allowed an initial uncovering and insight into some of the discourses being explored.

2. Interpretive reading of the texts for overarching themes and interconnections with other documents. Documents and interview transcripts were examined for overarching themes, repetitive motifs, consistent language. Intertextuality, or the examination of how the texts relate to one another, was the primary goal for this reading and stage of analysis (Fairclough, 1992).
3. Interpretive reading of the texts through the lens of the four pillars of Dean's governmentality analytic (visibility, episteme, techne, and identity), utilizing questions previously identified, in order to examine how regimes of practice relating to HCO QI function.

Trustworthiness

There is no standard or formally established methodology for the completion of a Foucauldian Discourse Analysis (FDA), as Foucault himself did not identify a standardized approach to discourse analysis (Cheek, 2004; Springer & Clinton, 2015). As such, the evaluation of trustworthiness in a FDA is complicated due to the multiple, situation-specific approaches that can be applied to a FDA (Nixon & Power, 2007). It has been suggested that epistemologically, it is more congruent to take a post-positivist parallel approach to the evaluation of "rigor" in discourse analysis research, as uncovering truth or fact is not the goal of a FDA (Nixon & Power, 2007). Rather, a FDA's goal is for the researcher to uncover meaning and interpretation in the texts that are analyzed, which the author from hereon out refers to as *trustworthiness* (Nixon & Power, 2007). This parallel approach to rigor aims to establish a means of evaluating whether the analysis conducted is of high quality, grounded, sound, and coherent, rather than whether the conclusions are "true" in the positivist sense of the word (Nixon & Power, 2007). It has been suggested that one way to accomplish this type of trustworthiness is through visibility of the

research process, where researchers can transparently illustrate their analytical process to readers (Sandelowski, 1993). Hence, to establish trustworthiness, this author documented all decision-making processes of the analysis and interpretation of the data throughout the analysis portion of the research, a strategy identified as "chronicling" (Greckhamer & Cilesiz, 2014).

It has also been suggested that for FDA research, researchers can achieve trustworthiness through increased accountability. This can be actioned by thoroughly detailing decisions and logic regarding the selection of texts, how researchers move between texts and interpretation, and what methodology is being used to guide analysis (Cheek, 2004; Greckhamer & Cilesiz, 2014). Guided by the identified need for accountability in decision-making in FDA research, the following questions have been presented by Crowe (2005) to help establish trustworthiness, which are answered by the author below.

1. Is the research question a good fit for discourse analysis?

As previously described, the aims of this research are as follows: to explore and identify the dominant discourses that structure QI in healthcare, how these discourses impact the nursing work and experiences of APNs, as well as to identify and bring attention to alternative or subjugated discourses regarding QI that may exist in healthcare. The research questions that were used to achieve this aim are as follows: what are the prominent discourses that shape current understanding of and experience with QI in healthcare? What forms of subjugated knowledge and discourse emerge in QI-centered spaces in healthcare organizations? How do QI discourses in HCOs shape the experiences of APNs in their professional capacity? Given that the uncovering of dominant and subjugated discourses as well as their impact on APNs in the healthcare system is central in the research questions, they are a good fit for a discourse analysis as they provide an opportunity to explore the social and political milieu where discourse occurs,

thus allowing researchers to both uncover discourse and its influence on the individuals within the milieu.

2. Do the texts support the analysis of the research question?

The selection of texts supports the research aim to identify and bring attention to discourses surrounding QI in healthcare. This author aimed to uncover the discourses via exploration of two different types of texts, CNS interview transcripts and historical documents. The selection of these texts allowed for the discourse analysis to be approached from two different lenses. It allowed for the author to historically situate the discourses surrounding this topic, consistent with genealogical approaches to discourse analysis previously presented in Foucault's research. It also allowed for exploration of the discourses in the present social milieu of participant experiences, allowing for discourse analysis to occur at a micro, social level.

3. Have sufficient resources been considered?

During phase 2, interpretive reading, of Dean's interpretive analytic framework, this author read between the interview texts and historical documents with the goal of identifying common themes, motifs, and language. During this phase, chronicling was completed, where the author made note of new themes that emerged from the data as they appeared, noting the commonalities between the various data sets. During this process, rich data and intertextual themes were drawn from the resources; a point was reached where no further themes emerged and rather the data continued to present with repetitions in the intertextual themes that were previously identified. The chronicling of this process and consideration that was given to the data in the research supported the author's conclusion that sufficient data (both historical and interview data) had been collected to support achieving the thesis' aims.

4. Has the interpretive paradigm been explicated?

The interpretive paradigms, both in the foundational theoretical concepts of the thesis and the conceptual pillars that ground the thesis' analytic framework, were explored in depth. The author provided conceptual definitions of *discourse, knowledge/power,* and *governmentality* in the theoretical foundations chapter of this thesis. The author went on to define the pillars of analysis used in the thesis' analytic framework, *visibility, episteme, techne,* and *identity*, thus demonstrating evidence that the interpretive paradigm has been sufficiently explored.

5. Are all of the processes used in the study congruent with this paradigm?

All the research's processes are congruent with the selected paradigm. The research is grounded in the Foucauldian concepts of discourse, knowledge/power, and governmentality. Dean expanded on Foucauldian conceptualizations of governmentality in his own work and went on to develop an analytic framework that provides a stepwise process for discourses and the technologies of governmentality to be uncovered. Careful consideration to the theoretical paradigm of this thesis have been given in its methodological design.

6. Does the author provide a detailed analysis of the data and analysis processes?

Yes, the author reviewed the analysis processes thoroughly in the methodology chapter of this thesis. Furthermore, the results of the analytic process were described in detail in this chapter.

7. Are the descriptions adequate for the reader to follow and understand the contexts thoroughly?

Descriptions of the analytic processes were detailed in a stepwise fashion in the methodology chapter of this thesis. Along with the step-by-step descriptions of how analytics took place, definitions for the foundational pillars of the analytic framework were also provided.

Detailed chronicling of the research was completed throughout the analysis of the texts, ensuring that the above questions were thoroughly answered in all stages of the research process via a reflexive journal. This chronicling, as well as the detailed answering of the questions relating to accountability of the selected methodology identified above, are presented in the final thesis to achieve trustworthiness. Additionally, the thesis supervisor, who has experience in conducting critical discourse analyses, supported every step of the research process, also serving as a means of upholding trustworthiness.

Summary

In this chapter, an overview of the thesis' methodology was provided. This overview was comprised of an introduction to FDA methods and strategies, including genealogy, as well as a detailed description of Dean's Governmentality Analytic, the analytic method used to guide this thesis' intertextual analysis. A summary of how both textual and participant data was collected was provided, as well as an overview of the textual data (7 selected historical documents) and participant characteristics (7 CNS participants) that resulted from data collection. Ethical considerations for the study were discussed; additionally, the considerations that were taken by the author and thesis committee to ensure trustworthiness of the study and analytic methods were provided.

Chapter 5: Results

Following through with the methodology of this thesis, results were obtained in the form of historical documents via genealogy, semi-structured interviews with eligible participants, and intertextual analysis of these documents. The results of this thesis are presented in four sections. First, to provide the historical context in which QI moved from the managerial/industrial sector to the healthcare sector, a historization of healthcare QI is provided. Next, a chronological overview of the historical drivers of healthcare QI are reviewed. Next, the author accounts the results of Dean's governmentality analytic framework, which, recalling from this thesis' methodology chapter, is broken down into two sections: problematization and interpretive analysis (Dean, 2010). The problematization of *QI in healthcare* is reviewed and supported with historical data., and finally, the results of the interpretive analysis, presented as three distinctive overarching discourses, *hierarchy, regulation,* and *performance* are presented. The results of the interpretive analysis are presented in a way that reflects the intertextual analytic framework of this research, in which the author moves between evidence from historical documents and interview transcripts in a fluid manner.

Historization of Quality Improvement in Healthcare

In the late 19th and early 20th centuries, healthcare quality was disorganized and largely dependent on the skills of individual practitioners (Luce et al., 1994). There was large variation in the training provided to healthcare practitioners and in the services that they delivered (Luce et al., 1994). To address the large variation seen in healthcare delivery, the organization of quality assurance regulatory bodies in healthcare began forming in the mid 1900s, including the Joint Commission on Accreditation of Hospitals, founded in 1952 as a collaborative initiative between Canadian and American physician associations, which established and evaluated what they

determined to be minimum standards and optimal standards of healthcare delivery in hospitals (Luce et al., 1994). Healthcare organizations (HCOs) electing to participate in accreditation processes could subsequently be measured based on these pre-determined standards; any shortcomings identified guide HCOs quality improvement (QI) initiatives to subsequently meet the standards outlined by accrediting organizations.

With the formation of healthcare quality regulatory bodies, including accreditation bodies, came pressure to standardize the evaluation of quality measures in healthcare (Luce et al., 1994). One individual who largely drove the movement towards health quality evaluation standardization was Avedis Donabedian, a physician and scientist. Donabedian's 1966 paper titled "Evaluating the quality of medical care" is largely considered to be one of the foundational guides for health quality evaluation in healthcare. Donabedian's work served to establish three guiding principles for quality evaluation: structure, process, and outcome (Ayanian & Markel, 2016; Banerjee et al., 2012; Donabedian, 2005). Donabedian also identified ideals to guide the assessment of quality in healthcare, including the need for reproducibility in standards of care, "patient-centered" outcomes, and a focus on metrics and measurable standards when evaluating quality (Donabedian, 2005). Donabedian's principles of quality evaluation continue to inform how HCOs and the healthcare sector define quality to this day (Ayanian & Markel, 2016; Banerjee et al., 2012).

Quality assessment and evaluation discourse in healthcare became widely accepted and unquestioned in the mid to late 20th century. Around this time, healthcare administrators identified the need for structured QI as a way to address gaps in quality uncovered in health quality assessments and to meet the cultural shift in healthcare towards Evidence-Based Practice (EBP) that had begun to take place in the 1960s (Banerjee et al., 2012; Schroeder et al., 2019). In

1991, the Institute for Healthcare Improvement (IHI) was founded in the USA with the goal of pursing QI in healthcare on a global scale (Banerjee et al., 2012). The IHI initially tasked itself with the goal of rigorously uncovering what were deemed the "best" approaches to healthcare delivery and translating these approaches to "practice guidelines" that could be utilized to improve the practices of healthcare practitioners worldwide (Banerjee et al., 2012). As QI and EBP continued to take hold in the healthcare sector, nearly a decade later, the Institute of Medicine (IOM) declared that QI would lead the direction of healthcare moving into the 21st century and identified six guiding principles for the improvement of quality in healthcare: safe, effective, efficient, patient centered, timely, and equitable care (Koyle et al., 2018).

QI has, and continues to be, largely been driven by external and organizational pressures rather than by individual healthcare clinicians and practitioners (Koyle et al., 2018). These external agencies and HCOs rely on various structured methodologies and frameworks to guide QI in healthcare which have origins in business and management frameworks rather than healthcare frameworks (Koyle et al., 2018; Migita et al., 2018). Healthcare QI frameworks widely accepted and utilized today include the Plan-Do-Study-Act (PDSA) framework, Lean principles, and Sigma Six principles (Koyle et al., 2018; Migita et al., 2018). These healthcare-adapted QI frameworks have origins that can be tied back to industrial and manufacturing management scholars and leaders, including W. Edwards Deming, Walter Shewart, and Joseph Juran (Koyle et al., 2018; Migita et al., 2018). These methodologies, guided by their manufacturing and industrial roots, utilize frameworks aimed at improving quality by reducing variation, cost, and waste, while increasing efficiency and standardization (Koyle et al., 2018; Migita et al., 2018). Healthcare QI has historically and continues to be guided by business, manufacturing, and industrial principles rather than principles with foundations in healthcare.

Chronology of quality improvement drivers in healthcare

Since QI became widely accepted and utilized in HCOs in the 1990s, there has been a multitude of drivers for QI related changes and initiatives in the healthcare sector. One of the principal drivers of healthcare QI has historically been and continues to be cost reduction (Banerjee et al., 2012; Koyle et al., 2018; Luce et al., 1994). With growing concerns over fiscal pressures and shortcomings at organizational, provincial/state, and national levels, value-based care, where healthcare performance is defined as a ratio of quality to cost, has been identified as a model to move healthcare forward in a cost-conscious environment (Koyle et al., 2018). In the USA, QI efforts were also identified as a means to potentially drive down costs associated with medical malpractice on the healthcare system (Luce et al., 1994).

The large-scale acceptance and desire to implement Evidence-Based Practice (EBP) in the healthcare system has also been a driver of QI. With the cultural shift towards EBP in the 1990s, furthered by the founding of the Cochrane Collaboration, a charitable organization dedicated to aiding the promotion and translation of EBP, in 1993, QI was looked to as a way to ensure the delivery of EBP in the healthcare sector (Banerjee et al., 2012; Parry, 2014; Schroeder et al., 2019). QI was largely regarded as the "translational" tool that could move EBP into practice using standardized frameworks and implementation strategies (Banerjee et al., 2012).

Large external organizational pressures for QI also exist in the healthcare sector. These external drivers for QI predominantly include external accreditation organizations. HCOs are required to utilize QI in order to meet growing numbers of accreditation standards around quality and safety (Schroeder et al., 2019). There are also a number of external organizations who are founded with the purpose of moving HCOs towards QI, including the Institute for Healthcare Improvement, whose organizational goals include helping HCOs achieve improved patient and

community outcomes, improved patient experience, and lower cost through QI (Schroeder et al., 2019).

The changing healthcare landscape in North America has also driven a turn towards QI. Significant changes to population demographics, population health and epidemiology continue to require change and improvement in healthcare systems (Oksuzyan et al., 2020). Rapid, unprecedented changes in healthcare and health records technology have driven the need for QI in HCOs (Salmond & Echevarria, 2017; Schroeder et al., 2019; Shannon & French, 2005). Downsizing of the healthcare provider workforce in Canada (as a result of sweeping austerity measures), particularly during the 1990s has also further driven the need for QI to increase efficiency in light of the gaps left by a reduction in health human resources (Shannon & French, 2005).

There is also strong desire at organizational, provincial, and federal levels for healthcare organizations to achieve the desirable outcomes of quality improvement projects, which include better patient outcomes, better system performance, and better professional development (in the form of enhancing "scientific knowledge" and "the knowledge of disease biology") (Batalden & Davidoff, 2007, p. 2). Researchers highlighting QI implementation across different healthcare organizations often tout measurable successes and improvements in specific quantitative outcomes, contributing to further drive for HCOs to engage in QI activities. For example, a systematic review found that 88% of studies that examined the effectiveness of Lean and Sigma Six methodologies in improving surgeries found significant improvements post-QI intervention in measures including reduction of cost, reduction of length of stay, increasing operating room turnaround and improvements in prophylactic antibiotic use (Mason et al., 2015). A second systematic review examining the application of Lean and Sigma Six QI methodologies in the

field of radiology found positive benefits associated with the QI interventions in all of the studies examined, including reduced cost, reduced wait time, and improved patient satisfaction (Amaratunga & Dobranowski, 2016). There has been evidence to demonstrate that QI projects have led to benefits including improved antibiotic management, decreased adverse drug events, and increases in childhood immunization rates (Shortell et al., 1998).

As previously discussed, healthcare QI has evolved significantly over the last century. In the early 1900s, QI frameworks in healthcare were non-existent, and gradually over the next 100 years there has been a movement towards defining, structuring, organizing, and accepting the role of QI in the healthcare field (Koyle et al., 2018; Schroeder et al., 2019). Today, QI is widely accepted as an integral piece of healthcare delivery and its position within healthcare remains largely unchallenged, allowing healthcare organizations to continuously implement QI related practices, initiatives, and policies that impact all levels of healthcare delivery (Koyle et al., 2018).

Problematization of quality improvement in healthcare

Dean identifies the first step of an analytic of government as "problematization." For the author to engage in a governmentality analytic of *healthcare organization quality improvement*, problematization of quality improvement in healthcare must first occur, where the author uncovers when and how healthcare quality was initially conceptualized as a problem in which governance strategies needed to be deployed. Problematization of HCO QI was achieved via examination of historical texts, which allowed the author to appraise the language used to discuss, describe, and contextualize HCO QI when discussions around HCO QI first framed *quality* in healthcare as a problem in need of governance. Berwick's 1990 book *Curing Health*

Care was found to be the first chronological point in the document analysis in which *quality* was framed as a problem, and as such was selected to ground the problematization of QI in healthcare.

A readthrough of the preface and first chapter of *Curing Health Care* allowed the author to problematize healthcare quality improvement; more specifically, it allowed the author to contextualize how *quality* in healthcare became framed as a problem in need of addressing by *QI* governance strategies. In the 1970s, with the introduction of neoliberal-ideologically driven policies and restructuring of the healthcare system in the USA and abroad, attention turned towards healthcare costs as an issue in need of addressing (Berwick et al., 1990, p. 5; Sakellariou & Rotarou, 2017). In line with neoliberal ideologies, healthcare policies were put in place to drive down the cost of care, including market-driven solutions such as "foster competition… let market forces drive down prices" and "limit the total payment… using the force of regulation and the power of the checkbook" (Berwick et al., 1990, pp. 5–6). The focus on cost-containment within HCOs continued throughout the 1970s and 1980s and was a focal point in defining the problems associated with quality in need of addressing via governing strategies, as identified in *Curing Health Care*.

Within the body of text in *Curing Health Care,* variability was prominently framed as the second problem with quality within healthcare organizations. Variability of care in HCOs is framed as a "rampant" and "slam-dunk variation" issue in need of addressing via governance strategies (Berwick et al., 1990, p. 7). At the point in time of publication of *Curing Health Care,* variation between healthcare providers and between individual organizations is irrevocably linked to quality and to the public's ability to trust HCOs: "the evidence on variation makes

simple trust in the quality of care seem naïve" (Berwick et al., 1990, p. 8). Variation is a problem in quality to be addressed, whereas standardization is the goal.

Practitioner-led judgement and decision making occurring within individual healthcare organizations is also framed as a problem in quality of care within HCOs. Control over decision making in care trajectories is conceptualized as an issue of accountability, as justification for clinical choices was framed as informal and non-regulated. This is framed as a problem with consequences including malpractice, inefficiencies, and fears that individuals will "cut quality corners" to maximize their own profits in a pay-per-service payment system (Berwick et al., 1990, p.7).

Within this problematization, quality in HCOs, is thus framed as "providing superior service at lower prices" (Berwick et al., 1990, p. 15). In 1990, the problematization of quality in HCOs frames the problems with quality as high cost, highly variable, and practitioner-led care. The call for strategies of governance to address these problems of quality can be seen initially in 1990, with the publication of *Curing Health Care* and henceforth since.

This problematization of quality thus grounds the results of the governmentality analysis of this research and allows the author to center the discourses uncovered in the analysis, specifically *hierarchy*, *regulation*, and *performance*, in their governance of the conduct of quality in HCOs.

Discourses of hierarchy in governance

Via analysis of the interview transcripts and historical texts, discourses of hierarchy in the governance of QI in HCOs were identified in all spheres of governance. Grounding the concept of hierarchy in Foucauldian theory can help guide the definition that will be used in this analysis,

particularly the relationship between power and knowledge grounds how *hierarchy* is conceptualized. As previously discussed, power is not wielded by individual people or entities but is rather transmitted through the social and political milieu (Foucault, 1980). Foucault does not conceptualize hierarchy as an entity held by any one individual or structure but rather links it to processes of normalization in forms of knowledge and the ways in which some forms of knowledge are embraced while others are rejected (Foucault, 1978). This results in a hierarchy of acceptable language and acceptable forms of knowledge. This hierarchy of acceptability wields power and governs over individuals and institutions via normalizing actions where expected behaviors, thoughts, attitudes, and processes are established within social and political structures, and where those that transmit acceptable forms of knowledge hold power. Through this conceptualization of hierarchy, findings which highlight the ways in which hierarchy is emmeshed in the governance of QI in HCOs are presented.

Hierarchy within healthcare organizational structures

Both interview participants and historical documents highlight the ways in which QI is governed via hierarchies embedded within the organizational structures of HCOs. These hierarchies are essential in governing QI practices, activities, and priorities in HCOs.

Participants positioned HCO executive management at the top of the QI hierarchy, identifying the high degree of authority that leadership holds with regards to vision setting, priority determination, and decision making in QI activities. This hierarchy creates conditions within HCOs where senior and executive management act as gatekeepers to QI. As one participant vocalized, to get approval and support for any QI initiative, you need “the right

stakeholders at the table, [to make] sure that you have senior management buy in, that you have buy in from the organisation" (P7).

And while the authority that management holds in QI governance was a recurrent theme amongst participants, they also identified the ways in which executive management in HCOs are also subject to pressures from the provincial health authority, adding an additional layer of complexity to the hierarchical structures of governance in healthcare QI. Participants discussed the ways in which the QI priorities of senior management must line up with the priorities of regulatory and health authority bodies. One participant summated the deep entrenchment of hierarchy in QI authority that they have witnessed in their experiences as a CNS in the following statement: "I have never, in the last 10 years, seen any initiative taken that wasn't mandated by somebody above them (P6)."

Participants reviewed how hierarchy within HCOs limits how effectively different professionals can engage in QI. Participants highlighted that organizational hierarchies create barriers to QI engagement and priority determination, particularly among patient-facing staff:

> The majority of the big quality improvement decisions are generally made from top down. I think that if a patient-facing worker came up with a quality improvement initiative, it would be much harder for them to get traction and be heard when talking to leadership because leadership decides where funding goes and it's what they ultimately decide (P1)

Participants also reflected on how HCO hierarchical structures regulate their identities as CNSs within the organizations. When analyzing data, a stark difference was noted in the experiences of CNSs who were unionized compared to the experiences of non-unionized, leadership-based CNSs. The unionized CNSs identified that they hold less authority in QI compared to management and leadership within their organizations as they are left out of crucial

strategic planning conversations. The unionized employees reflected on how, within their HCOs, strategic planning and large-scale organizational improvement planning occurs within the confines of management teams due to the limits that organizations set on who can participate in planning; there is a perception that unionized employees must be left out of strategic planning for reasons relating to confidentiality and insufficient authority to engage in larger organizational planning. One participant highlighted this while reflecting on their professional constraints as a unionized employee, "[this] makes my position unique because I have no authority. I'm a nice employee; I've absolutely no authority, but yet you need to implement change" (P2). Another participant described being excluded from conversations relating to QI evaluation and planning, stating that "you're left out of all of that because you're unionized, or at least in our organization you are" (P2). These experiences contrast with the experiences of non-unionized CNSs, who highlighted that they benefited from organizational hierarchies in their roles as they could leverage their positions within the organization to move forward nursing-centered priorities in QI leadership conversations:

> The CNS role is something that can bridge that [hierarchy] and allow us to have a seat at the table for these types of decisions and these types of discussions that normally are usually like, you know, executive level people in positions of leadership, but then no nursing representation (P4)

Visibility plays a large role in the legitimization of organizational hierarchies in QI. Several participants identified the presence of formal QI committees and working groups that guide QI decision making. Names of these groups varied from organization to organization as identified by participants, ranging from titles such as "quality improvement team" to "advisory councils" to disease-specific working groups. These groups provide a setting for visible, formal QI conversations to take place and legitimize the processes involved in the planning,

implementation, evaluation and dissemination of QI; “we have quarterly meetings where we talk about our statistics and performance and get feedback” (P7).

The role that executive management hierarchical structures play in governance of QI activities in HCOs is not surprising upon examination of the historical documents, which review the forms of knowledge that guide QI processes. Historical documents outlining QI theory and methodology, including *Crossing the Quality Chasm*, “Comparing Lean and QI,” and “The Breakthrough series,” and Ontario Health’s “QIP guidance document” all place organizational management at the center of QI. Language mandating strong, sustained, committed leadership in HCO QI activities persist across all documents. For example, “Comparing Lean and QI” states that “creating a truly Lean health care organization requires a transformational commitment by leadership, followed by a steadfast, long-term commitment to building improvement capability throughout the management hierarchy.” The documents also place an emphasis on the inherent responsibility of management to sustain QI activities within organizations, emmeshing accountability for QI success within the identity of the QI leader in HCOs. Looking specifically at the Ontario context, Ontario Health stated that “clinical leaders are critical to improvement efforts and developing a culture of quality within an organization… all those in leadership positions are accountable for implementing and supporting the organization’s QIP” (Ontario Health, 2024). These documents highlight the ways in which hierarchy and identity in HCO leadership intersect in the governance of QI.

Hierarchy in physician authority in QI

Participants repeatedly relayed experiences which highlighted the hierarchal positionality that physician identity holds within HCOs QI spaces. Most participants described ways in which physicians are seen as voices of authority with regards to QI priority setting. Physicians are seen

to "always have more pull in the hospital" with regards to setting QI priorities (P3). One participant highlighted this while reflecting on how a specific QI initiative that they were working on was initially brought forward: "the only reason that got put in is because [the physicians] said it had to come in" (P6). This voice and authority sharply contrasted that of nurses in HCOs, who, per the participants, are not seen to have the same level of authority in QI determination:

> the last QI project I did was 100% motivated because a physician complained to our medical director. So the need was identified by a physician… it was really one complaint, and that was impressive, because it's an issue that everybody knew about for a long time and it wasn't until a physician complained that it was like 'oh, we're gonna fix this' (P5)

Participants highlighted that often, nurses alone do not have the voice or the authority to bring forward QI priorities or areas of concern, and instead require the collaboration of physician colleagues to gain traction on issues of concern. One participant, reflecting on the ways in which HCOs perceive nursing, expressed that "[nursing] expertise is not recognized or valued unless it's in conjunction with a doctor" (P6). Another participant highlighted how the hierarchical nature of physicians in HCO QI both enable and constrain what becomes an issue of priority within the HCO, identifying that "when we have experienced success at [quality improvement] work, it's been when a patient-facing staff identifies something, and a physician also thinks it's interesting" (P5). Contrarily, nurses or other patient-facing staff may run into difficulties gaining support and resources for QI initiatives if they do not impact physicians, or as P5 voiced, nursing issues are "not a priority… because it is not a physician problem."

Physician authority within HCO QI hierarchies is enabled in multiple ways. Physicians hold positions of authority and sit at tables on various committees and groups in HCOs which enable the construction of their identities as leaders and voices in QI. Participants identified that

the roles that physicians hold as department heads, medical directors, leaders of larger regional care groups, and others allow legitimize their identities as QI leaders and allow them to have a table to voice their own QI priorities. This hierarchy is also reinforced structurally in the job expectations, roles, and responsibilities that physicians hold in addition to their role in clinical care. Scholarly responsibilities, often mobilized in the form of research and/or QI, is entrenched in the job descriptions of many physicians and as such the dedicated time and resources to carry out QI are provided to physicians, further legitimizing their authority in QI leadership. As one participant related, "physicians are highly motivated [to conduct QI], often they have academic appointments to maintain. QI is a part of their professional obligations in many places, and they get reimbursed for it" (P5).

Historically mapping the prevalence of physicians in QI literature increases understanding of the ways in which hierarchies in physician authority in QI have been developed and reinforced over time. This can be traced back to the origins of QI in healthcare in Donabedian's 1966 "Evaluating the quality of medical care," a paper whose explicit purpose was to evaluate the quality of physician centered care and critically appraise the evaluation methods used to evaluate physician care. Physician centered conceptualizations of quality and quality evaluation persist throughout other historical documents analyzed and is particularly evident when examining the roots of QI methodology development and dissemination via the IHI. The IHI was founded by a physician, Donald Berwick, who helped to set out a transformative vision and roadmap for QI work in healthcare. The IHI places a high degree of focus and attention on leadership as the center of QI within HCOs. In HCOs, emphasis on leadership translates to physician leadership in the form of medical directors, research leadership, and committee leadership, which is mirrored in participant experiences within Ontario HCOs.

Contrasting the high level of emphasis placed on physician knowledge and authority in QI spaces, there is a notable absence of nursing-centered knowledge and authority in the historical documents. Tracing back to the first chronological document from the thesis' genealogy, "Evaluating the quality of medical care," the document focuses on quality relating to medical care exclusively. This is reflected in the stated purpose of the paper, which identifies that it "deals almost exclusively with the evaluation of the medical care process at the level of physician-patient interaction" (Donabedian, 2005). There is no reference to nursing care or nursing knowledge; the only reference to "nurse" in the entire document is when the author refers to "nurses' notes" as a source of medical records that can be used in QI evaluation. This exclusion of nursing from QI discourse in healthcare endures over time; there is no reference to nurses or nursing in the sections of *Curing Health Care* that were appraised in the genealogy, while "physician" and "doctor" are referenced extensively through the document. In *Crossing the Quality Chasm*, nurses are only referenced when listing examples of healthcare professionals, but always in conjugation with other professionals including physicians and never as a standalone. Nurses are not referenced in either IHI white paper document studied.

Ontario Health's QIP document identifies that patient-facing care providers, including nurses, must be engaged in the QIP process as "early involvement in identifying and defining the scope of actions for improvement is critical to the success of any quality improvement initiative." However, no standards on how these professionals are engaged and how their feedback is integrated into the QIP are identified, demonstrating further evidence of the absence of nursing identity is in QI centered spaces.

Hierarchy in acceptable forms of knowledge

Data from participant interviews and historical documents reveal a hierarchy in acceptable forms of knowledge relating to QI in healthcare. Forms of knowledge grounded in positivist epistemology hold a higher degree of authority compared to other forms of knowledge and experience. Positivism is based in the idea that knowledge is grounded in observable and measurable phenomena which can be obtained via empirical research (Steinmetz, 2005). Positivist school of thought holds high authority in the knowledge hierarchy in QI and is reflected in the forms of knowledge that direct QI priorities, such as practice standards, best practice guidelines, and disease specific standards of care. Participants frequently cited best practice as the core driver of QI, "I would like to point out that best practices are best evidence… I think it makes sense that our work goes back to that" (P7). Positivist realms of thought that ground HCO QI work can be historically traced to Donabedian's "Evaluating the quality of medical care," where Donabedian identifies the following:

> Empirical standards are derived from actual practice and are generally used to compare medical care in one setting with that in another, or with statistical averages and attainable levels of care and, for that reason, enjoy a certain degree of credibility and acceptability (Donabedian, 2005).

Through the decades following the publication of "Evaluating the quality of medical care," organizations critical in moving forward HCO QI initiatives continued to reinforce this hierarchy of knowledge, holding best practice guidelines and standards of care to a high level of authority. In their publication of *Crossing the quality chasm*, the Institute of Medicine defined effective care as "care that is based in scientific knowledge" (Institute of Medicine, 2001). In 2004, with the initiation of the IHI's "Saving 100 000 lives in the USA" campaign, the IHI encouraged the implementation of six specific evidence-based interventions across hospitals in

the USA; they went on to attribute implementation of these positivistic-knowledge grounded guidelines to lives saved, adding an element of visibility to the legitimization of this knowledge hierarchy (McCannon et al., 2006).

Participants reflected on how this hierarchy of acceptable forms of knowledge can limit what constitutes improvement in HCOs. Specifically, participants reflected on how quality is not defined by the users of the system, including patients and nurses but instead is defined by physicians, executive managers, and governments, who as noted, disproportionality utilize positivism to determine QI measures and metrics. One participant reflected on how qualitative and experiential forms of knowledge that ground nursing care are not translated to QI in HCOs, resulting in neglect of subjective understandings of quality in healthcare:

> it's [nursing] very much qualitative, that art of actually caring and being present as Watson [nursing theorist] would say, for the patient and the value that brings to humans and people. But it's not measurable within medicine and money, and so it's not as valued (P6)

Participants identified beliefs that the focus on empiric measures in HCO QI is also a result of convenience, as alternative measures of quality are perceived as more difficult to capture in quality evaluation. One participant, in reference to qualitative patient experiences, described them as "subjective and not as measurable and take an extreme amount of time to measure" (P6), thus resulting in them not being considered in QI initiatives. Another participant described the same challenges with regards to measuring non-quantitative aspects of nursing care, stating "I'm really passionate about the soft skills in our job, that I think are maybe more important than some of the other things but harder to measure" (5), going on to describe how the difficulty with quantifying these skills translates to them not being prioritized in QI. This results in definitions of quality being reduced to individual empiric outcome measures rather than a

more fulsome, multifaceted conceptualization of quality. Rationale for using empiric outcome measures as indicators for quality can be traced back to the publication of Donabedian's "Evaluating the quality of medical care," where he goes on to describe that "many advantages are gained by using outcome at the criterion of quality in medical care… outcomes tend to be fairly concrete and as such, seemingly amenable to more precise measurement." Participants identified examples where empiric outcome measures in the form of highly specific clinical care protocols and care pathways establish organizational QI priorities, with one participant succinctly remarking that "[the ministry's] perspective is so general and so high level that they almost can't give a specific mandate unless it's to treat a very specific situation. You know, like gestational diabetes will have such and such a protocol [with specific outcome measures] and then everyone has to implement it" (P6). These hierarchies act at the individual and larger healthcare system levels to regulate the conduct of QI in healthcare, deeming some QI activities as acceptable while rejecting others.

In summary, through Dean's governmentality analytic framework, an analysis of data from historical document data and participant interview data revealed the ways in which discourses of hierarchy appear and are enacted and enabled throughout HCO QI spaces. Hierarchy in QI appears throughout HCOs in the form of structural hierarchies enabled by multi-tiered leadership systems, with each tier holding varying levels of discursive authority. There was also evidence of hierarchy in HCO professional identities as evidenced by the high degree of authority and visibility in HCO QI held by physicians, contrasting with the largely absent nursing voice and authority in the context of HCO QI. Lastly, the data revealed hierarchies in acceptable forms of knowledge within HCO QI spaces, as evidenced by positivistic, empiric forms of knowledge dominating healthcare QI discourse, while silencing alternative forms of

knowledge. Having examined data in this thesis' research relating to discourses of *hierarchy* in HCO QI, attention will now be turned to discourses of regulation.

Discourses of regulation

Discourses of regulation were identified via a governmentality analytic of participant and historical data. Once again, the author turns to the thesis' theoretical underpinnings to ground understanding of what constitutes discourses of *regulation*.

Foucault and Dean's conceptualizations of governmentality provide a strong foundation for understanding discourses of regulation. Recalling from previous chapters, governmentality can be understood as an intersection between knowledge, power, discourse, and the strategies used to regulate subjects within a social or political milieu (Dean, 2010). The subjects of governmentality are not necessarily individuals, but are also families, social groups, and political structures (Dean, 2010). Governmentality regulates behaviors not by overt controlling practices, but rather via implicit practices and proliferation of acceptable forms of knowledge within a specific milieu (Dean, 2010). As such, discourses of regulation in the context of this thesis can be conceptualized as the observable incidences where power, knowledge, discourse, and governing strategies intersect to control, change, or limit the actions or behaviors of HCOs or individuals within HCOs.

Regulation of QI via governing bodies

Examples of QI regulation via governing bodies were prevalent throughout participant interviews. Participants identified Accreditation Canada, the provincial health authority, and external organizations such as the Registered Nurses Association of Ontario (RNAO), as bodies that govern and regulate QI within HCOs in Ontario. Participants described how these governing

bodies achieve regulation by mobilizing a multitude of technologies. For example, accreditation organizations regulate by establishing pre-selected accreditation standards that organizations are required to meet to garner organizational accreditation and remain compliant. As a result, many QI initiatives are targeted to meet and maintain accreditation standards. As one participant stated, "some of [QI] is just based on, what are the accreditation standards [that need to be met]?" (P2). The provincial health authority in Ontario, also referred to as the ministry of health, achieves regulation via various mandates, many of which are tied to HCO funding, thus ensuring HCO compliance. Per the participants, the ministry of health mandates HCOs to collect and report on specific quality indicators, which results in organizations tailoring their QI efforts towards improving these metrics. These mandates can result in QI compliance for the sake of compliance rather than for the sake of improved care, as one participant describes:

> it's definitely more outside pressures, like accreditation, or funding… I don't think it's really reflective of best practice either… things have not been considered that we have glaringly huge gaps for standard of care... but it's [QI priority setting] coming from outside, it's coming from I think, more of the punitive 'we need to do this or else' instead of reflection of you know, 'we can provide better care for patients and ,how can we go about that to provide better care for them?' (P4)

Desire to improve an organization's reputation results in regulation of QI activities within HCOs. One participant explains how there are "different accreditations you can apply for as a centre" (P1) and how desire to achieve these reputational accreditation statuses drives QI targets.

Historical documents also reveal the ways in which discourses of regulation related to governing bodies have evolved over time. In *Curing Health Care*, Berwick (1990) discusses the increased role of government in the regulation of HCOs, highlighting that "almost every level of government is moving more deeply into surveillance of both care and finance in medicine (p. 9)."

Historical document data reveals how the regulation of HCOs by government agencies emerges over time. In 2001's *Crossing the quality chasm,* the Institute of Medicine puts forwards the recommendation that government bodies should "continue to authorize and appropriate funds for… monitoring and tracking processes for use in evaluating the progress of the health system," reinforcing the role of government health authorities in QI regulation (Institute of Medicine, 2001). Ontario Health's quality improvement plan (QIP) guidance documents highlight the technologies that are used in the local context by the provincial government to regulate HCO QI. Ontario Health requires all provincial HCOs, including hospitals, to develop annual QIPs where priority issues are pre-selected from a set of themes established by Ontario Health that "describe province-wide areas of focus" (Ontario Health, 2024). Furthermore, Ontario Health pre-establishes "standardized, evidence-based measures of health care quality" that hospitals must use to evaluate QI outcomes (Ontario Health, 2024).

Regulation of QI methodology

Participants and historical documents both highlighted the ways in which the methods used to guide QI activities are regulated within HCOs. Participants identified that within their organizations, highly regulated QI frameworks were used to guide QI activities. One participant described how Lean-informed daily huddles are built into the daily activities on patient-facing units within the hospital: "each unit has their daily huddles, which is all part of the lean methodology" (P3). Participants also describe how Lean strategies and IHI-informed PDSA-cycle improvement strategies are used to guide improvement, "our hospital is very keen on using [QI methodologies], some Lean methodology" (P2). These QI frameworks hold a lengthy history of regulation; historical documents identify that organizations that led the development of QI frameworks pulled from managerial science frameworks to guide the development of guidelines

that have since become well-established QI frameworks. In "Comparing Lean and quality improvement" the IHI specifically describes the ways in which Lean and IHI QI drew from automobile and manufacturing QI experts including Juran, Deming, and Shewart, and translated manufacturing QI models be applicable in the healthcare sector (Scoville & Little, 2014). Visibility enabled the proliferation of and organizational compliance to these QI methodologies, as QI leaders developed visually pleasing, easily shareable QI toolkits and materials, with step-by-step instructions on how to successfully apply these models within HCOs.

Despite participants identifying that highly regulated QI methodologies are used within their HCOs, participants described varying degrees of individual training in these methodologies, contributing to wide-ranging experiences. Some participants identified that their organizations paid to have them trained in QI frameworks, including one participant whose organization paid for them to have Lean certificate training, despite their role being primarily clinical care oriented: "I did take my Lean Greenbelt" (P3)." Other participants identified that through their own personal interest and educational pursuits, they had achieved certification, education and training in QI methodology and translate this training to their professional duties, "[my research experience] is where I learned about quantitative and qualitative analysis. This is where I learned the basics of how to do a study, the PDSA cycle, all those things" (P5). This participant, despite being in a leadership-oriented CNS role, identified how essential their prior educational background and interests were in being competent in QI and in being able to independently move forward QI initiatives. Other participants, however, identified that they had not had opportunities for training in QI methodologies in their educational or professional experiences. One participant, whose roles and responsibilities encompassed both direct clinical care and system leadership, reflected on how this limited their ability to effectively engage in QI work despite QI

being a significant part of their work portfolio: “how do you improve quality when they haven’t necessarily given you the tools to know how to do it? How do you change practice when you never really have been taught how to change practice and improve quality” (P1).

Participant data also revealed how regulation of QI methodologies contributed to issues of workplace satisfaction among staff. One participant discussed how the more rigid QI frameworks used in their hospital contributed to a degree of discontentment from patient-facing nurses. Participants described the perception that due to the regulated QI structures employed by HCOs, patient-facing nurses’ contributions towards QI priorities exist in theory but do not necessarily translate to reality: “[patient-facing staff] say to us ‘wasn’t QI supposed to be bottom up?’ We don’t feel like there’s space for us to bring things towards the table because everything’s coming from top down” (P4). This participant expanded on this sentiment, explaining the following:

> I think largely it is senior leadership who decides on QI objectives and I think that the intention of … CQI is supposed to be more of a grassroots movement where we’re hearing from the patient-facing staff and moving things through QI so that we can improve their work experience and workflow and work safety… and we’re not able to do it in a way that is meaningful for staff, and so it’s hard to get them to connect with it (P4)

Regulation of QI evaluation

The data revealed the ways in which QI evaluation within HCOs is also heavily regulated. To explore how specific forms of knowledge have legitimized regulation in QI evaluation, an examination of Donabedian’s “Evaluating the quality of medical care” is insightful. Specifically, Donabedian, in his accounts of how to evaluate quality in healthcare, identifies that using pre-selected outcome measures allows for convenient measurement in

quality evaluation, stating, “outcomes tend to be fairly concrete and as such, seemingly amenable to more precise measurement” (Donabedian, 1966).

QI evaluation regulation is further reinforced by the QI frameworks used in healthcare. Lean management outlines that evaluation in QI should be centered around outcome measures. Per such instruction , QI project designers should: “specify one or more measures that characterize the current state and the ideal state… Specify the goal as target level(s) of the measure(s)” (Scoville & Little, 2014, p. 11). Additionally, IHI’s QI model identifies that to evaluate quality, outcomes must first be selected. In IHI’s step-by-step QI guide, one question asks: “How will we know that a change is an improvement? …team members identify appropriate measures to track their success” (Institute for Healthcare Improvement, 2003, p. 7).

Participant experience further highlights how using predetermined outcomes in quality evaluation in healthcare is normalized among individuals in these spaces. One participant, reflecting on their own process in QI determination, identified, “I can identify the problem based on data, I can identify the problem and know where I want to get to” (P2).

Benchmarking, another metric-centered evaluation tool, is also used in the regulation of QI evaluation HCOs. Ontario Health’s QIP guidance documents identifies that when selecting QI targets in HCOs, each QI target must be justified and identifies benchmarking as an acceptable tool for QI target justification:

> describe why your organization selected the quality improvement targets for the coming year. Explain if this target is based on meeting recommended benchmark performances, aligning with provincial performance, or evidence-based best practices (p. 13).

Examples of benchmarking are also mirrored in participant data; one participant described using benchmarking to set their own priorities and to evaluate their QI efforts:

"comparing yourself to another organization is another way to see that… if you have a peer who's really performing highly, how can we do what they're doing?" (P7).

Regulation in QI evaluation is also evidenced by the ways in which QI is conceptualized as an ongoing, continuous cycle of improvement. The predominant manufacturing and assembly-line QI philosophies that ground modern HCO QI frameworks, as outlined in "Comparing Lean and QI" stress that for QI to be effective, there must be "Kaizen," which translates to a continuous search for opportunities for improvement and an ongoing commitment to change (Scoville & Little, 2014). Lean frameworks stress "an organization's cultural commitment to… continuously improving the work delivered by teams of people, leading to measurable better value for patients and other stakeholders." QI models invoke continuous change cycles, including IHI's Plan-Do-Study-Act (PDSA) cycles of learning as described in detail in IHI's "The Breakthrough series," which involves cyclical trial and evaluation of QI initiatives. At the local health system level, regulation of evaluation is further reinforced by Ontario Health's mandates on annual renewals for QIPs for all HCOs in the province, which translates to a legislated requirement for HCOs to engage in regulated, cyclical evaluation of quality measures.

Participants reflected on the impacts of continuous, cyclical QI evaluation on patient-facing staff experiences with QI, identifying that it can limit staff engagement with QI. One participant noted that predetermined QI measures were reviewed with patient-facing staff continuously on a weekly basis. This contributed to a sense of frustration in staff as they felt limited in their ability to explore quality issues outside of these specific QI measures:

> it's not to say that staff don't care, it's just that they have different priorities in their day to day… they're like 'okay**,** why are we spending every week talking about this when I am having other issues not addressed that do affect me and my ability to do work' (P4)

Another participant reflected on how the focus on continuous cycles of improvement limited their organization's ability to effectively evaluate their QI projects. They discussed how the continuous nature of QI evaluation limited the organization's ability to dedicate time to reflect, explore potential process shortcomings and understand staff experiences with QI, instead evaluation was perceived as superficial and inconsequential:

> it's gonna cost us more money to try and do the evaluation piece, [fulsomely] so they just don't… it just ends up getting like kind of forgotten… [leadership] just moves onto the next one [QIP], they find another, they don't think too hard about it [evaluation], they just abandon the initiative and move on to the next QI initiative (P1)

CNS regulation of self in QI

CNSs, both as individuals and as a group within the healthcare system, can be seen as subjects to a discourse of regulation as it relates to QI. They are subject to the various power structures and technologies of governance that exist within the social and political milieus that constitute HCOs.

CNSs within this milieu are exposed to a series of expectations surrounding acceptable behaviors and thoughts; this enables conditions in which CNSs conform to these expectations via self-regulation practices (Rose, 1993). However, grounded in Foucault's conceptualization of subjectivity lies the idea that CNSs have the freedom and ability to self-regulate their own thoughts and actions in resistance to accepted norms and practices (Dean, 2010). Examples of both can be seen throughout the interview data of this thesis. Interview data highlighting *regulation of the self* of CNSs was rich, as interview questions were designed to explore the experiences of CNS participants. However, as previously discussed, nursing and nurses were largely absent in historical document analysis, with most attention turned towards the identities and forms of knowledge held by physician and healthcare leadership. As such, data supporting

this section is largely derived from participant interview data rather than historical document data.

Conforming to QI.

Participants identified the ways in which they regulate themselves, both consciously and subconsciously, to conform to the expectations of QI leaders within their HCOs and to be effective in their QI work.

During interviews, many participants explored the ways in which they embraced their subjectivity as QI leaders and professionals within HCOs. Participants discussed the ways in which they self-regulated their professional interests and educational pursuits to increase their knowledge in QI methodologies to be better QI leaders. This was true for participants, regardless of their work portfolios and consistent with CNSs who engaged primarily in system leadership and those who had portfolios which included patient care domains. One participant reviewed how this pursuit of skills in QI methodologies is essential to garnering support for their QI work within their organization: “I feel like I have to have my own skill set when it comes to QI if I want to get that stuff done” (P5). One participant described how she embraced her roles both as a QI leader and as a CNS and noted that by linking these two identities together, she is able to assert herself as a QI authority within her HCO: “because my position is a CNS, I can argue that these are the pillars of being a CNS and [QI] is just part of it and I can advocate for that” (P2).

Some participants described some of the ways they gain internal validation and role satisfaction from engaging in traditional QI activities. Participants described satisfaction from QI activities involving problem identification in HCOs via quantitative data analysis, satisfaction from cost savings QI outcomes, and achieving best practices and standards of care through QI

mobilization: “I just have such a drive to see people having the opportunity to identify a problem, then measure it in different ways” (P7). Participants also described seeking out opportunities for integrating QI into their daily work even when it is not mandated, demonstrating a form of regulation of the self in participants. One participant conveyed this by describing the following: “I’ve always been able to have a QI project on the go, partly because I am interested in it, partly because I believe education should be done in a scholarly way and continuously evaluated” (P5).

Participants revealed that to successfully move forward their own QI priorities, they had to strategically self-regulate the way in which they presented their priorities to HCO leadership, ensuring they fit within greater organizational priorities. This strategic form of self-regulation ensured that they could self-determine QI priorities while still garnering organizational and resources, “If you were to come in and do a project and you were like ‘how could I get buy in,’ I’d say focus on something that will decrease our wait times and you’ll get buy in right away” (P5). One participant described the role of strategically self-regulating in relation to timing of QI. This participant describes how pushing forward or delaying a QI initiative, depending on current corporate priorities, can make or break whether support is obtained:

> to get engagement with the facility, it either has to line up with standards that are out there or has [to line] up with your corporate standards, right? There are corporate priorities and if it’s not gonna line up with those, it’s just not going to happen… you just have to sit on it a little bit before you can move forward because the timing has to be right for it (P2)

Participants explored the role of autonomy in QI determination within their scopes as CNSs. While participants did identify that working within and conforming to HCO QI

frameworks was essential, they described how autonomy and self-determination of priorities contributed to satisfaction in their roles and in their QI work:

> I'm happy that I also get some influence and freedom over that because you notice problems in your day-to-day work that you're like 'we can solve this.' So being able to kind of put that forward and develop a quality project… is also really rewarding (P7)

Other participants identified how self-regulating their time and task management was essential for ensuring that QI work could be effectively completed in their roles. Participants described how despite their organizations' acknowledgment of CNSs as clinical experts and valuable QI professionals, that value did not always translate into resources such as protected time for QI work. Many participants described how in order to accomplish QI work, they need to engage in self-regulation by either framing their QI work as relevant to the organization's larger strategic plan or by actively scheduling time for QI in their busy workdays, "if there's a clinical need you either have to be really dedicated to kind of protecting it [time] or making sure it's in your strategic plan" (P7). This sometimes included doing QI work in their own unpaid time, such as during unpaid meal breaks, after work hours or on weekends:

> sometimes the QI is on my own time because I want to get it done… there may be times where I am doing it on the weekends just to make it happen. It is a nice to have, but not a need to have… so if I wanna be engaged in QI, sometimes it's up to me to just make it happen on my own time (P5)

These experiences further highlight the way in which nursing identities and nursing knowledge are not consistently given authority or legitimacy within QI spaces, adding additional context to previous discussions around discourses of hierarchy and hierarchy of knowledge.

Resisting QI

Participants also demonstrated various behaviors consistent with resistance towards some of the governing QI discourses. One participant discussed the way that they engaged in strategic

protesting within their HCOs to move forward their own QI priorities. They discussed how intimate knowledge of the QI drivers within their HCO enabled them to engage in acts of protest with the goal of mobilizing their own priorities. Strategically utilizing these QI drivers ensured that leadership would move forward QI priorities that were important to the CNS, when these priorities were previously dismissed when framed in ways that less explicitly aligned with institutional QI priorities:

> leadership would not support us enough to get it done and as a result we had to start putting in safety calls… so basically we went above our leadership and said, 'no, you're gonna do something about this' (P6)

This example demonstrates resistance to the discursively created identity of *good agent of QI* and rather reveals how this participant embraced their own subjectivities to strategically mobilize change in the HCO milieu.

Other participants reviewed the ways in which they challenged the widely accepted discourses that define quality in healthcare, instead internally embracing alternative definitions of quality of care, "it's quality if it's saved the hospital money, which I think is a little messed up because quality should be determined by the level of care that we're providing patient, right?" (P1). Participants identified that the widely accepted discourses around quality in healthcare did not resonate with their own definitions of quality, and how these divergences brought forward conflicts with their fundamental nursing values: "as nurses, that's our core, we want people to feel good, we want them to be well beyond disease, we want them to feel healthy fully, mind, body, soul" (P6). They did identify that holding alternative definitions of quality made it difficult to mobilize QI priorities, "if you really are doing it truly on the side of your desk as, like, I don't

know, a pet project that's of interest to you, but your team, your manager, your patients haven't said "yeah, this is important, we need to do it," it's a lot harder to be successful" (P7).

Participants discussed the ways they leverage their clinical expertise and the scope of their roles to enable participation in QI work that is relevant to them, "[my QI work] is very focused on my specific role… I'm rarely forced into something that I don't think is of value" (P3). Other participants, however, identified feelings of disconnection and decreased motivation when being pressured to engage in QI work that is not meaningful to them, or when "being pigeonholed by the organization" (P4). Experiences where the participants were implicitly and explicitly pressured into QI work that was not meaningful to them by HCOs contributed to dissatisfaction, disengagement, and internally resisting their identities as QI leaders:

> When being pressured to do something that you don't believe in, it makes it a lot harder to carry out for sure… those are things that motivate you to not like your job anymore and want to change and leave and go back to school… it does create a resentful sort of, you would lose your purpose and job satisfaction… it would be grounds for changing jobs for a lot of people I think (P1)

In summary, evidence of discourses of regulation, understood as the ways in which behaviors, thoughts, and actions are implicitly and explicitly controlled in the intersection between knowledge, power, discourse, and regulation strategies, are found throughout this thesis' research data. Discourses of regulation appear in many forms in HCO QI spaces, including the regulation of QI activities in healthcare via explicit and implicit forces from multiple healthcare governing bodies. It is also observed through the regulation of QI methodology, where via the ways in which QI activities are carried out is highly regulated. Discourses of regulation are further evidenced in the sphere of QI evaluation, notably via discursive constructions of what QI evaluation is and what "good" QI outcomes are. Finally,

evidence of regulation of self in CNSs as it relates to QI in healthcare was explored, with a focus on the ways in which "positive" behaviors relating to HCO QI are enabled in CNSs and, contrastingly, exploring the ways in which CNSs engage in implicit and explicit acts of resistance to the discourses that dominate HCO QI.

Discourses of performance

Discourses of performance were identified throughout historical and participant data. To more effectively describe how discourses of performance are observed in research data, the author first grounds the definition of "performance" in Foucauldian conceptualizations of knowledge, power, and governmentality. Foucault explores how the power that knowledge wields enables it to be both a productive and a limiting force, both enabling the production knowledge that is deemed acceptable and simultaneously limiting alternative forms of knowledge (Best & Kellner, 1991a, p. 49). Acceptable forms of knowledge wield significant power in the social and political milieu (Foucault, 1978). Governmentality sees that acceptable behavior is enabled by setting acceptable norms and standards that are tied to acceptable forms of knowledge; acceptable practice is established and differentiated from non-acceptable practice (Dean, 2010). With these conceptualizations in mind, performance can be viewed as varying degrees of adherence to the acceptable forms of practice and knowledge within a specific social or political milieu. Good performance can be understood as strong adherence to established and accepted norms and forms of knowledge. The author will now explore the ways in which discourses of performance were observed in the data.

Cost reduction as performance in QI

Within the frameworks of QI in healthcare, cost reduction is synonymous with performance. Interview participants made statements including the phrases "cost-savings," "cost-effective," and "money saved" to describe HCO performance indicators in quality improvement. One participant, when describing their own performance in a QI initiative, identified "I can go back and I can look at my day and look at how much money we've saved" (P2). Historical document analysis reveals that a high level of attention has been placed on cost reduction as an indicator of performance in QI for decades. In Berwick's 1990 *Curing Health Care*, the author highlights that "cost, more than anything, is driving the change" (p. 5). He identifies that QI can be enabled to "foster competition… let market forces drive prices down" and "encourage better management of care… create financial incentives to encourage efficiencies," mirroring many of the fundamental underpinning philosophies of neoliberalism including the promotion of free-market solutions to problems of inefficiencies in healthcare (Berwick et al., 1990, pp. 6–7; Sakellariou & Rotarou, 2017).

Increased costs are framed as wasteful and indicative of inefficiencies, whereas cost reduction is framed as increased performance in the healthcare system. A decade later, in *Crossing the quality chasm*, the IHI identifies efficiency, or avoiding waste, as one of their six specific aims for improvement, further reinforcing the link between cost reduction and performance in the healthcare system and highlighting how performance discourses penetrate HCO QI. Historical document tracing also reveals the strategies and mechanisms used to enable performance discourses around cost reduction in HCO QI, including the ways in which government agencies engage in systematic surveillance of finances, with a notable focus on cost

reduction. As Berwick identified in 1990, “almost every level of government is moving more deeply into surveillance of both care and finance in medicine.”

Both participants and historical documents reveal that while quality healthcare remains a priority, quality is not prioritized unless it is coupled with cost savings performance. IHI’s 2003 “Breakthrough series” identifies that its goal as a QI framework is to “help health care organizations make ‘breakthrough’ improvements in quality while reducing costs.” One participant, reflecting on how HCOs define performance, identified that cost efficiency remains a top priority in performance alongside maintenance of a minimum standard of care:

> I think that hospitals and organizations define success by how much money a quality improvement initiative has saved them and not sacrificed patient care. So it’s like a balance of the two of them, how much money have we saved versus the level of care stayed the same (P1)

Quantitative results as performance in QI

Links between performance in QI and measurable, quantitative results permeated both the interview and the historical document data. Participant data and historical document data frame performance in QI as statistically improving measures relating to desirable quality indicators or reducing measures relating to undesirable indicators.

The prominence of the relationship between quantitative results and QI performance can be seen throughout participant interview data. One reflected on the prominence of quantitative data in all realms of QI in HCOs: “I don’t think the average nurse or patient-facing staff realizes how much data the hospital pulls from the electronic charting and how that is used for numbers to support quality improvement” (P1). Participants discussed how quantifiable measures and targets are set by HCOs to guide QI initiatives, including “patient, patient stats, patient outcomes, infection outcomes, follow up outcomes, discharged from service outcomes” (P1). Another

participant reflected on how meeting these quantitative targets would constitute good performance in HCOs: “the metrics are where they are looking at in terms of how they can prove that their system is improving (P4).”

The link between quantitative results and performance has been discursively enabled for decades, dating back to Donabedian’s “Evaluating the quality of health care,” where he identifies that in healthcare, there is a search for “discrete, readily measurable data that can provide information about the quality of medical care” so to avoid a “costly and laborious” multidimensional assessment of care. Donabedian’s reflections around linking measurable data to quality performance is mirrored in participant data, as one participant identified “I think we are skewing towards quantitative. I think it’s easier to be like ‘hey, we decreased the amount of consult we did by this much’ and then pat ourselves on the back or whatever” (P5).

As QI experts sought to develop more formal healthcare QI models in the 1990s and early 2000s, they turned towards statistics as a means of measuring performance. In “Comparing Lean and quality improvement,” the IHI identifies how both IHI-QI and Lean rely on manufacturing QI leader Shewhart’s “statistical process control” to determine QI goals and measure QI performance. This is further evidenced in Ontario Health’s QIP guidance document, which states that all HCOs in Ontario must measure and monitor improvements via process measures which “must be quantifiable and reportable as rates, percentages, or numbers over specific timeframes.”

The identity of “QI leader” within HCOs is also linked to quantitative performance. There is incentivization of desirable leadership behaviors related to achieving performance targets. One of the most explicit examples of this type of governance is seen in Ontario Health’s

QIP guidance documents, which review that "executive compensation must be linked to the achievement of performance improvement targets outlined in the QIP." This financial incentivization of quantitative-based performance reinforces discourses of quantitative results as performance in HCOs and further normalizes behaviors relating to quantitative performance in QI leadership. Perceptions relating to expressions of these discourses are observed in interview data, as one participant identified, when topics of performance management arise in HCOs, "it's not 'how can we support your staff to provide better care in a safe way'… it's, 'how can we support you to hit this number?'" (P4).

Discourses of performance rely on using visibility tools in governance to discursively uphold the concept of performance as quantitative results. One example that highlights this visibility was identified in the historical document data, in reference to the IHI's 100 000 lives campaign. In this campaign, we see the way in which the IHI visibly links quantitative outcomes, specifically the claim that 100 000 lives were saved via the implementation of QI initiatives, to positive performance in QI. This campaign, used as a marketing tool for the IHI's QI initiatives, helped to visually spread messages around HCO QI performance to the public and to HCOs across the USA. Furthermore, additional historical data, including the IHI's Breakthrough Series and Ontario Health's QIP guidance document recommend utilizing visual tools including charts, progress reports, and presentations that easily communicate quantitative changes in QI evaluation metrics, reinforcing the role that visibility plays in governance of performance in HCO QI. Participants relayed experiences that further suggested that visibility is linked to tying quantitative results to performance in QI; many discussed how improving the way that quantitative results look in various measurement tools including charts, presentations, and spreadsheets is prioritized in the communication of "good performance" in QI. As one

participant succinctly stated, “there isn’t a lens of, how can we provide best care for patients, it’s like, how can we make sure that we’re fitting numbers appropriately in a spreadsheet, we’re hitting this target?” (P4).

In summary, evidence of discourses of performance in QI were revealed through the analysis of this thesis’ results, where, grounded in Foucauldian knowledge, performance is conceptualized as adherence to acceptable forms of knowledge and practice within a specific social or political milieu. Discourses of performance in QI are actualized and enabled in the ways in which healthcare organizations conceptualize what is good performance in QI. Specifically, discourses of performance in QI are enabled via the conceptualization of cost reduction and quantitative result achievement as good performance in QI.

Summary of results

Throughout this thesis’ results chapter, many topics were explored. First, the historization of healthcare QI and a chronology of the historical and current drivers of healthcare QI were presented. Then, using Dean’s analytic framework to guide understanding of *problematization*, this author engaged in the problematization of *healthcare organization quality improvement,* where the author pulled from historical document data to uncover and describe when and how quality in healthcare was conceptualized as a problem in which governing strategies needed to be executed to address the problem. Here, the author examined how in the 1990s, following the widespread adoption of neoliberal policies in healthcare, highly variable, costly, and practitioner-led care were constructed as problems in healthcare in need of fixing. Lastly, an exploration of the major discourses uncovered in the research’s analytic process, notably discourses of hierarchies in QI, regulation in QI, and performance in QI, were discussed. Specific examples of

where these discourses were constructed, enabled, and enacted within the social milieu that is healthcare organizations, were explored using data from both participant and historical document data.

Keeping these discursive themes in mind allows a deeper exploration into the impacts of predominant QI discourses on the nursing profession and on the provision of care within HCO spaces; it allows for consideration of how these discourses are immersed in HCO spaces and allows for the consideration of implications for nursing education, research, practice, and healthcare governance. The implications of this thesis' results will be explored further in the next chapter.

Chapter 6: Discussion

This thesis' research aims were broadly to explore and identify the dominant discourses that structure QI in healthcare, how these discourses impact the nursing work and experiences of APNs, as well as to identify and bring attention to alternative or subjugated discourses regarding QI that may exist in healthcare. The following research questions: *what are the prominent discourses that shape current understanding of and experience with QI in healthcare, what forms of subjugated knowledge and discourse emerge in QI-centered spaces in healthcare organizations?* and *how do QI discourses in HCOs shape the experiences of APNs in their professional capacity,* answered via participant interviews and historical document analysis, allowed the research aims to be met.

Using Dean's governmentality analytic framework to analyze participant interviews and selected historical documents, discourses of *hierarchy, regulation,* and *performance* were uncovered as the dominant discourses that structure and influence QI in healthcare. Evidence of these discourses emerged throughout the relayed experiences of CNSs as they encounter QI in their workplaces and was further grounded via the examination of documents related to healthcare QI in a genealogic analysis. Research findings will now be re-rooted in this thesis' theoretical underpinnings and will be further contextualized in existing literature and contemporary nursing practice issues. Recommendations for nursing practice will be presented under each subheading of this chapter rather than as a standalone section due to the iterative nature of this discussion and the recommendations that subsequently emerged from this space. Finally, the limitations of this research and concluding statements are presented.

Governance of the Clinical Nurse Specialist Role

Recalling Foucauldian conceptualizations of governmentality allows for CNS participants experiences to be theoretically contextualized. As Dean (2010) reviewed, an analytic of governmentality is the exploration of the technologies, instruments, and mechanisms employed to "conduct the conduct" within a social or political milieu. Dean (2010) identified that in the study of governmentality, in any given space, there are many intermeshing regimes of practice that act in and direct conduct within these spaces. As such, looking within the space of healthcare QI, there are a large number of regimes of practice acting to direct and regulate the conduct of the individuals and groups within that space. Examining specific technologies employed within healthcare QI processes relating to CNS practice provides insight into the experiences of CNSs in the QI space. Reflecting specifically on identity, defined by Dean (2010) as "the forms of individual and collective identity through which governing operates" (p. 43), the identity of the CNS as it is situated within healthcare QI can be explored as a technology of governance within this space.

Identity is a tool of governance employed which aims to regulate the statuses, attributes, capacities of those who are governed, as well as their conduct, the duties that they have, and how these duties are fostered and ensured (Dean, 2010). CNS identity shapes internal and external understanding of what the CNS role is (and is not), what knowledge a CNS holds (and does not hold), what their capacities are (and are not) and what types of roles and responsibilities they should (or should not) engage in.

CNS participants discussed the roles and identities of CNSs in hospital settings, including insight into the roles and capacities that they hold in the HCO QI space. Reflecting on the five pillars of Advanced Practice Nursing, as outlined by the CNA pan-Canadian framework-which serve to structure key elements of identity construction, APNs are expected to engage in direct clinical care, education, leadership, research, and consultation and collaboration competencies in their workplaces (Canadian Nurses Association, 2019). As previously reviewed in the introduction and literature review chapters of this thesis, APNs leadership competencies and intimate knowledge of clinical care issues position APNs to be uniquely qualified leaders in QI spaces in healthcare (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018). Through examination of interview results, it becomes clear that the participants had broad ranges of work experiences, duties, and scopes within their individual workplaces, notably in the context of participation in QI-related work, despite all identifying as CNSs who work in Ontario-based hospitals. This highlights the large degree of variability in CNS roles in Ontario hospitals that are largely dependent on individual organizations and leadership within HCOs. These results demonstrate how *identity* of CNSs is not consistent throughout different spaces in Ontario healthcare, and how this lack of consistent understanding of CNS identity contributes to difficulties in the governance of CNSs in Ontario HCOs; without a clear identity, the conduct, capacities, and attributes of CNSs are not well understood and subsequently not well governed in HCO spaces.

These experiences are also reflected in extent literature examining CNS roles and experiences in Canada. A survey of CNSs in Canada and internationally found large variations in the understanding of the CNS role among members of the healthcare team, HCO leadership, and health legislators, impacting the working experiences of CNSs in HCOs (Donald et al., 2010). A

second study explored how CNSs engage in the different pillars of the CNS role and found that the more the CNS engages in direct clinical care, the less likely they are to engage in other pillars, including leadership and research (Kilpatrick et al., 2016). In a different study, authors explored factors that contribute to CNSs choosing to leave CNS roles and found that lack of role clarity and inability to implement all dimensions of the CNS role were key factors in decisions to leave CNS roles (Kilpatrick et al., 2014).

This thesis' results demarcate a difference in the way that *identity* of CNS is governed in academic and regulatory settings compared to various practice settings. This thesis' research highlighted themes surrounding lack of voice and authority in CNS identity construction and enactment, noting how CNSs lack "authority" or a "seat at the table" with regards to quality improvement initiatives (P2). It also revealed themes surrounding CNSs lower hierarchical positionality in HCOs compared to those with alternative identities, such as senior leadership or physician. *Identity governance* in these healthcare settings limits the ability of CNSs to fully utilize their scope of practice, notably limiting their capacity to engage in leadership spheres of the CNS role, which minimizes their ability to share nursing expertise and knowledge in QI spaces. The governance of CNS identities within Ontario hospital structures in ways that minimize their abilities to contribute to QI negates existing literature, which consistently brings attention to how CNSs are uniquely and well positioned to be leaders in QI spaces in healthcare (Aplin, 2020; Diaczun & Miller, 2023; Lewandowski & Adamle, 2009; O'Sullivan, 2022; Schoales et al., 2018).

Examining *identity* as a technology of governmentality for CNSs in HCO spaces has resulted in the creation of the following policy recommendation: Ontario healthcare authorities

should engage in a strategic deployment of a CNS workforce optimization plan. There is significant lack of role clarity for CNSs,, variations in competency expectations, and variations in educational preparation for individuals working in CNS positions. All these factors are reflected in the experiences of this thesis' research participants. Furthermore, as evidenced by the experiences of research participants, this lack of role clarity contributes to inconsistencies in job descriptions and working experiences of CNSs; CNSs roles vary greatly from one organization to the next and are highly dependent on who is managing individual CNSs and individual manager understandings of the CNS role. A structured CNS workforce optimization plan, such as the one being recommended by nurse leaders in British Columbia (BC), would promote increased consistency of CNS roles, responsibilities and better support engagement with necessary competencies (Lambert & Lauck, 2025). The provincial deployment of such an optimization plan, which includes policy recommendations such as "standardize the CNS job description and center CNSs in recruitment and hiring decisions," "CNSs must report to a senior nurse leader (or designated leadership body, e.g., a CNS Council) who understands and supports the role…," and "CNSs and senior nursing and organizational leaders must prioritize strategies to promote CNS role clarity, and the role of each CNS must be aligned with organizational priorities" would contribute to greater role clarity among healthcare professionals and would more effectively promote the creation of CNS roles which incorporate all spheres of CNS practice, including leadership and health systems optimization (Kilpatrick et al., 2013; Lambert & Lauck, 2025). Improved understandings of CNS identity would enable CNSs to have a voice and increased authority in QI spaces in HCOs, allowing them to lend a much needed nursing voice at QI tables. The framework presented by BC's health authorities provides recommendations for issues impacting the CNS profession, including role definitions and role

requirements, minimum academic preparation for the CNS role, and organization specific onboarding and continuing education guidelines to support ongoing CNS competency, leadership, and skills development (Lambert & Lauck, 2025) This optimization framework draws attention to the dynamic capacities of CNSs and the ability for CNSs to positively contribute to clinical leadership and to bring a nursing lens to healthcare system-level improvement and innovation (Lambert & Lauck, 2025). ;

Weaving a CNS workforce optimization framework into HCO spaces via provincial health authoritieswould serve to support improved understanding of the capacities and attributes that make up CNS work, and in turn allow CNSs to practice their full scope in workplace and practice settings in a manner that more closely aligns with the ways in which nurses conceptualize their own CNS identity. Such a framework could be used as a tool to disrupt current the discursive construction of CNS identity and enable the construction of a discursive identity which lends itself to increased authority and increased capacity to disseminate nursing knowledge in healthcare QI spaces.

The Subjugated Knowledge of Nurses

The results of this thesis' research brought attention to the theories and models that inform QI work in HCOs. Genealogic analysis revealed that HCO QI models are derived primarily from industrial management forms of knowledge and have been adapted over time for applicability to the healthcare sector. The consequences of this include change management that is hierarchal, top-down management driven, and that focuses primarily on measurable empiric metrics to evaluate improvement. QI priorities are structurally determined at the upper-management level within HCOs; the IHI's 2003 "Breakthrough series," provides instruction that

"leaders identify a particular area or issue in health care that is ripe for improvement." Language from participants, including "management priorities," "provincial priorities," "corporate standards," corporate priorities," and "strategic plan" are all further indicative of hierarchical QI structures in healthcare (P2, P7). These QI models also reinforce a hierarchy of knowledge, in which positivistic epistemological thought holds a higher degree of authority in QI spaces compared to other forms of knowledge. These dominant QI discourses also inform QI drivers, which focus primarily on the identification of measurable numeric improvements, cost-reduction opportunities and the standardization of care.

Simultaneously, the results of this thesis' research demonstrated how nursing knowledge and nursing voices do not carry the same currency as the positivistic forms of knowledge that ground HCO QI practice. In the results section, this translated to QI priority setting, methods, and evaluation metrics fitting within the boundaries of the accepted forms of knowledge in healthcare QI, notably positivistic knowledge, while concurrently neglecting other forms of knowledge, which often included the knowledge, expertise, and priorities held by nurses. Participants regularly discussed barriers in bringing forward grassroot, nurse-led QI initiatives, identifying that management and/or physician buy-in to QI initiatives act as structural safeguards in the QI determination process, resulting in further reinforcement of the status quo in HCO QI spaces.

Drawing from this thesis' theoretical underpinnings, the significance of Foucauldian knowledge/power dyad can help situate knowledge hierarchies relative to QI in healthcare. Foucault understood knowledge and power to be inseparable, as power enables the production of certain forms of knowledge while simultaneously oppressing others; power "doesn't only weigh

on us as a force that says no, but… it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault, 1980, p. 119). The knowledge and discourses found within HCO QI methodologies construct the social realities of healthcare professionals and guides their understandings of what are acceptable versus non-acceptable practices in QI work. Different forms of knowledge wield different degrees of power, where the thoughts and forms of knowledge held by subjugated groups do not hold the same level of authority as the widely accepted discourses, or accepted truths, at any given point in time. Recalling his examinations of hierarchy, Foucault described the expressions of the marginalized as "one whose discourse cannot have the same currency as others" (Foucault, 1981, p. 53).

This thesis' results were indicative of nursing knowledge being a form of subjugated knowledge within the HCO QI space. Participants reflected on nursing (as a discipline) and nursing staff holding differing priorities than management with regards to QI, "it's not to say that staff don't care [about QI], it's just that they have different priorities in their day to day" (P4). These findings are similar to existing published research. For example, despite evidence suggesting that nurses contribute positively towards QI when they are actively engaged, they remain "one of the most underutilized assets for leading QI initiatives" (Alexander et al., 2021). Strategic ignorance marginalizes knowledge to productive and maintenance the status quo; in other words, "certain claims have been excluded or marginalized for the sake of coherency of the system" (Cooklin, 2024). Ignorance of nursing knowledge is a strategically deployed in HCOs, allowing the status quo, which centers neoliberal forms of knowledge that prioritize cost reduction, decrease variability, and quantitative improvements, to be upheld (Sakellariou & Rotarou, 2017).

Despite the experiences of participants being largely exclusionary with regards to nursing participation in QI priority setting, intent to engage multiple levels of collaborators, including nurse leaders and patient-facing nurses, is built into HCO QI methodology. At the local level, Ontario Health's QIP guidance document dictate that HCOs must "engage key stakeholders," including patients, clients, and patient-facing staff, in their QI planning processes. These intentions, however, do not necessarily translate into actual involvement or perceptions of involvement on behalf of CNSs. The QIP guidance document does not provide guidance on how HCOs should engage these key collaborators, placing them at risk of tokenistic, or non-meaningful, engagement. Tokenistic engagement puts collaborators at risk of QI encounters that are "patchy and slow and often concentrated at the lowest levels of involvement… consultation is more often the norm, than collaboration" (Ocloo & Matthews, 2016).

This gap between intention with regards to QI engagement and actual experience with QI engagement, as evidenced in participant interviews, demonstrates fundamental flaws with the current QI process. Current methodologies, rooted in knowledge derived from the industrial management sector, do not give space for meaningful collaborative goal setting and collaborative QI planning where alternative forms of knowledge can be shared and valued. Instead, they reinforce hierarchical power structures and neoliberal forms of knowledge in HCOs while fronting an appearance of collaboration.

Participant data revealed that QI engagement with nursing knowledge through engagement with CNSs still requires nurses to engage in QI in a manner that fits within the confines of the acceptable QI models. Cost-reduction, standardization, numeric measurement improvements still need to be central to any nursing contributions to QI to gain traction; this was

particularly evident in the ways that CNSs strategically self-regulated the presentation of their priorities to HCO leadership to ensure that they fit within pre-determined organizational QI priorities. This style of engagement acts as a means of safeguarding the status quo; tokenistic engagement safeguards organizations from criticism of top-down style decision making by providing a form of superficial evidence that they engaged in collaboration, even when the collaboration is not meaningful (Ocloo & Matthews, 2016).

Thus, there is a need to abandon the industrial management derived QI models that currently govern HCO QI methodology and instead create new improvement models that are rooted in the subjugated knowledge and experiences of those who access and work in the healthcare system. Under current QI models, neoliberal thought and knowledge govern process, which strategically silences subjugated forms of knowledge including nursing knowledge which prioritizes caring over cost effectiveness and efficiency. Nurses bring a valuable voice and strong background of knowledge in patient care to the table and wish to see improvement in their workplaces as a QI outcome. Currently, however, nurses must align themselves with widely accepted QI discourses to participate in QI.

The technologies that reinforce the status quo of HCO QI, including the financial incentivization of leadership-driven QI in Ontario where executive compensation is linked to the achievement of leadership-led QI priorities, as demonstrated by Ontario Health's 2024 QIP document, need to be abandoned. Instead, HCOs and authorities that regulate HCOs should incentivize new QI models – built by and for *all* who are impacted by QI, models that promote meaningful knowledge sharing and distribution of power among various system collaborators, including CNSs

Such a foundational shift in QI discourse would be highly disruptive to the current system and would also disrupt and challenge the ways in which quality is understood relative to QI. To rectify this disruption, a reconsideration of what *quality* in healthcare means and what *quality improvement* in healthcare looks like is necessary

A Counter Narrative of Quality

Lastly, attention is turned towards gained understanding of how quality in healthcare is discursively defined in healthcare QI spaces. Examination of historical documents and participant data underpin that in healthcare QI, quality is synonymous with standardization, reduced variability, waste reduction and cost containment. Improvements in quality are closely linked to achieving measurable, quantitative improvements. Documents that outline widely accepted QI frameworks, including the IHI's "Breakthrough Series…," "Comparing Lean and QI," and Ontario Health's "QIP guidance document," all identify that to measure quality, you must be able to statistically measure the quantitative impact of improvement initiatives.

This thesis' research highlighted the ways that CNS conceptualizations of quality do not necessarily align with widely accepted discourses of quality in healthcare and brought attention to the ways in which the forms of knowledge held by CNSs are strategically subjugated in the context of QI. Participants eluded that for them, *good care* grounds their definitions of quality: "as nurses, that's our core, we want people to feel good, we want them to be well beyond disease, we want them to feel healthy fully, mind, body, soul" (P6); "I define care by the level of care I think my patients are receiving" (P1).

Nursing literature has brought attention to how conflicts between organizational conceptualizations of quality and nursing conceptualizations of quality contribute to moral and

ethical dilemmas amongst nurses and nursing leaders. Specifically, nursing professionals have concerns with how metric-based definitions of quality neglect to consider complex factors that contribute to quality nursing care, including patients' right to individualized care and right to refuse care (Ericson-Lindman & Strandberg, 2021). Nurse managers have identified how current QI structures contribute to moral and ethical dilemmas internally, as they feel pressure to abandon patient care and compromise their core nursing values to fulfil their employers' expectations in QI work (Frilund et al., 2023; Morrison & Jensen, 2022). This conflict can be framed as an ethical rupture resulting from tensions between ideologies of caring, which ground nursing values and culture, and ideologies of service and managerialism which currently dominate organizational change management (McMillan & Perron, 2020b). A closer look into the philosophical roots of this ethical rupture allows a more fulsome understanding of this conflict. Nursing scholars have situated the ethical practice of nurses within a framework of relational ethics, centering the relational nature of nursing care and using mutual respect, engagement, and embodied knowledge as grounding themes to guide ethical relationship development and decision making (Deschenes & Kunyk, 2020, p. 770). Within relational ethics, there is deep nuance, shying away from objective right or wrong; rather, what is ethical is rooted in a "commitment to care about those involved in the situation and to actively engage in the relationship" (Deschenes & Kunyk, 2020). Contrasting relational ethics to the values which inform neoliberalism, notably rigid attention to the identification of inefficiencies, cost-reduction, opportunities for standardization and empiric improvement measurements, the source of frustration and ethical and moral conflicts among nurses in QI spaces becomes apparent. The goals of relational ethics, which relies on subjectivity and uncertainty in a given situation,

contradict directly with the goals of neoliberally run health systems, which aim to take objective control over situations to garner improvements focused centrally on cost reduction.

Widely accepted definitions of quality in HCO QI do not align with nursing conceptualizations of quality, notably outcome measures that "[fail] to capture the heart of nursing and the meaning of quality nursing care for practicing nurses" (Burhans & Alligood, 2010, p. 1690). There are several articles that explore nursing perceptions on quality in healthcare, and they consistently identify the nursing value of *caring* as integral to how nurses define quality (Burhans & Alligood, 2010; Larrabee & Bolden, 2001). Burnhans and Alligood (2010) suggest that nurses define quality in six unique ways: advocacy, caring, empathy, intentionality, respect, responsibility (Burhans & Alligood, 2010). Contrary to standardized, metric-based conceptualizations of quality care, quality care for patients in a patient-centered manner results in care that is "highly customized" and can "improve the outcomes that patients desire" (Institute of Medicine, 2001, p. 49). This dissonance in discursive framing reflects struggle that Foucault discussed in the context of discourse. For Foucault: "discourse is not simply that which translates struggles or systems of domination, but the thing for which and by which there is struggle, discourse is the power which is to be seized" (Foucault, 1981, pp. 52–53). Through this struggle, CNSs have built what can be understood as a counter-narrative, outlining a definition of *quality* grounded in care-based knowledge and values. Such a definition may serve to build a necessary counter-narrative that challenges current discourse on quality in QI spaces in healthcare. Counter narratives can be understood as marginalized views which resist another, more powerful narrative (Lueg et al., 2021). Counter narratives are productive forces of change, which act in ways that destabilize the status quo (Lueg et al., 2021). Nursing scholars have described counter narratives as "attempts by people to prevent the loss of their identity and

not passively accept the ideas that others impose on them" (Holloway & Freshwater, 2007, pp. 708–709). In this sense, a counter narrative of *quality*, derived from nurses, can be used to de-stabilize the status quo surrounding current discourse in HCO QI and realign quality discourse. With this in mind, the following recommendation for healthcare scholars are presented:

Calls to better define *quality* in healthcare are not new. In Donabedian's 1966 document "Evaluating the quality of medical care," he suggests that studies of quality in healthcare are limited:

> most studies of quality suffer from having adopted too narrow a definition of quality. In general, they concern themselves with the technical management of illness and pay little attention to prevention, rehabilitation, coordination and continuity of care, or handling the patient-physician relationship. Presumably, the reason for this is that the technical requirements of management are more widely recognized and better standardized. Therefore, more complete conceptual and empirical exploration of the definition of quality is needed (Donabedian, 1966, p.716).

Unfortunately, this thesis' findings suggest these calls to redefine quality have not yet been sufficiently met. In the decades following Donabedian's call to action for improved conceptual clarity, the healthcare system saw growing pressures to turn to the free market to reduce costs and improve efficiency as a result of neoliberal restructuring of government and health agencies (Sakellariou & Rotarou, 2017). Under the pressures of neoliberal discourse, the healthcare sector saw the emergence of industrial-management derived QI models and conceptualizations of quality as a response to and means of addressing financial shortcomings in the healthcare sector. This, again, can be seen as an apt reflection of how discourse acts as a

productive force in the promotion of knowledge that maintains and advances the status quo, and an indication of the necessity of the disruptive force of a counter narrative to shift the status quo. When considering the results of this research and themes identified in outside literature, current forms of knowledge that inform discourses of quality in HCO QI are too narrow and do not fully capture the care-based values and relational ethics that guide nursing practice. Nursing scholars would benefit from engaging in a strategic analysis of what constitutes *quality* in healthcare and using that as a basis from which nursing groups can advocate to re-align QI work towards nursing-centered goals and priorities, as opposed to neoliberal and industrial management goals and priorities. Studies examining the ideological tensions that nurses currently face in managerial driven healthcare settings would suggest that such conceptual re-alignment of *quality* could attend to some of the moral dissonance nurses experience in their work (McMillan & Perron, 2020b).

Summary of Discussion

By means of a governmentality analytic of discourses related to QI in HCOs, this thesis called attention to issues surrounding the experiences of CNSs in Ontario-based hospitals. Exploring CNS experiences in HCO QI revealed issues around the lack of clarity with respect to the *governed identities* of CNSs, enabling an understanding of how lack of clarity in CNS identity hinders CNSs ability to fully engage in their scope of practice as expert nursing leaders and clinicians and brings attention to the need for increased CNS role clarity. This examination of CNS experiences in the sphere of HCO QI also revealed the ways in which nursing knowledge is subjugated in these spaces where managerial and neoliberal forms of knowledge dominate, drawing attention to the need for a re-balancing of knowledge and power within these spaces. Lastly, this discussion drew attention to the ways in which CNS and nursing conceptualizations

of quality differ from dominant HCO QI conceptualizations of quality, contributing to ethical and moral crises in the nursing workforce; these discussions underscore the imminent need to bring forward a counter narrative of quality in these spaces as a means of rectifying the current gap.

Limitations

As discussed in the literature review (Chapter 2) of this thesis, the literature review was conducted using methods more aligned with traditional thematic analyses rather than critical discourse analyses. As previously reviewed, the literature review was presented in this thesis as it unfolded chronologically in the author's research process; the methodology of the thesis was not known at the outset of the literature review. The author's knowledge of FDA structure and methods developed as the research progressed, reflective of the author's learning and growing as a graduate student. As a means of respecting the academic integrity of the research process, the literature review is presented in this thesis as it occurred. If the author were to complete similar research in the future, a literature review that is more aligned with methods associated with discourse analyses would be undertaken to increase the theoretical cohesiveness of the research.

Recruitment for this research proved to be difficult. One of the significant limitations during recruitment was the high level of specificity identified in the inclusion/exclusion criteria. CNSs represent a small portion of the nursing workforce in Ontario; reliable data on the number of CNSs employed in the province is also not available as CNS is not a protected title. Opportunities for employment as clinical nurse specialists are not equally available across all hospitals in Ontario and instead trend towards being clustered to larger health networks and hospital systems in the province; one study examining CNS employment trends in Canada

identified that 93% of self-identified CNSs were working in large urban centers (Kilpatrick 2013). Furthermore, this research excluded any clinical nurse specialist who had gone on to work in positions of hospital senior leadership, excluding potential participants who may have chosen to pursue higher management opportunities in their careers (this particular exclusion criteria resulted in three interested participants being excluded from participation). Attrition was also a limitation; two participants who reached out to the author via email expressing interest in participation could not be reached for further communication after informed consent documents were sent. One further participant withdrew from participation, citing scheduling/time limitations.

Snowball-method recruiting from participants who took part in interviews proved to be less effective than initially anticipated as well. These recruitment challenges are consistent with literature on recruitment of nurses as participants in research studies. Nurses are a difficult to reach study population, with work-related fatigue and high volume of requests for participation in surveys and studies in their professional roles being cited as some reasons for these recruitment difficulties (Bethel et al., 2021; White, 2012).

Generalizability is further limited by the highly specific work locales of the participants who took part in this research. All participants worked in urban hospital settings; this is consistent with national trends, as previously identified (Kilpatrick et al., 2013). Furthermore, due to the desire to recruit CNSs from workplaces that were more likely to have structured QI processes integrated within the organization, participants working in other settings such as community health or public health care organizations were excluded. These factors limit the research's generalizability as they do not account for factors such as geographical isolation,

resource limitations, or smaller-sized leadership structures that may impact rural hospitals or non-hospital-based healthcare settings. When considering these variables, discourses around HCO QI may emerge differently in such spaces than the ways that were identified in this thesis' research.

An additional limitation relates to the generalizability of the results across different jurisdictions. Due to the complexities of the Canadian healthcare system and the differences seen across health authority bodies with regard to a multitude of factors including healthcare funding structures, professional licensing bodies, and authorization of title protection, this author was intentional in the restriction to only include participants working in hospitals in Ontario. This allowed the author to explore discourse relating to a single identifiable locale. Ontario is a single-payer healthcare system that receives funding from the provincial health authority; the funding structures in Ontario may differ from other provinces under Canada's universal health system and do differ significantly from other countries which may not have publicly funded, single-payer, universal healthcare. Differences in funding structures may create differences in the pressures and conditions which influence and drive QI. Furthermore, differences in professional licensing requirements and differences in jurisdictional title protection may also contribute to difficulties with generalizability of how CNSs experience their work and are positioned within HCOs. To address this limitation of generalizability, researchers may consider replicating this research in an alternative setting where the aforementioned variables differ from the conditions that are seen in Ontario hospitals.

Concluding statements

Through a discursive exploration of key QI documents and CNSs experiences of QI, this thesis has brought attention to the ways in which discourses of *hierarchy*, *performance,* and *regulation* permeate QI in HCOs. Impacts of these discourses are seen in the ways that CNSs engage with and are limited in how they can engage with QI within their workplaces. Dominant QI discourses permeate the methodologies and frameworks which inform QI work in HCOs, resulting in the healthcare system widely embracing managerial, industrial-management derived QI models rather than considering or creating models that more suitably align with the values and ethics of healthcare providers, including nurses. Dominant QI discourses in healthcare also contribute to a narrow conceptualization of what *quality* means in these spaces, limiting how improvement is defined and thus impacting the types of initiatives that can be brought forward as QI.

The discussions around HCO QI so far in this chapter have centered on the challenges experienced and the constraining effects QI discourse has on CNSs abilities to engage in QI work. It is important to note, however, that the critiques presented are of the discourses that inform QI, not QI itself. QI remains an essential endeavor within the healthcare sector. Healthcare is not static; the sector must flow and adapt in response to the complex pressures of a landscape of ongoing changes to public health demographics, technologies, political environment, and treatment advancements, among others. Discourses that inform QI are dependent on power/knowledge relationships, whereby it is important to remember that while power can a limiting force, it is also a productive force in which knowledge is created; power "doesn't only weigh on us as a force that says no, but… it traverses and produces things, it induces pleasure, forms knowledge, produces discourse" (Foucault, 1980, p. 119). With

Foucault's conceptualization of power in mind, there is opportunity to challenge current QI discourse in ways that are productive, that reflect the values and knowledge of nursing professionals, notably CNSs. Ways in which CNSs may engage more centrally in QI, including influencing the discourse that drives it, are reflected in the three central recommendations made in this thesis: the deployment of a provincial CNS workforce optimization plan, replacing current HCO QI frameworks with frameworks grounded in nursing knowledge and expertise, and to further develop and mobilize a nursing-driven counter narrative of *quality* in HCO QI. These recommendations in action enable a disruption of the discursive status quo in this QI space, there is an opportunity to mobilize existing nursing knowledge in ways that are productive: that bring nurses and to the metaphorical and physical QI table to carry out QI in ways that benefit the nursing profession and the patients and populations that nurses care for.

References

Abrahamson, K., Davila, H., Mueller, C., Inui, T., & Arling, G. (2013). Examining the lived experience of nursing home quality improvement: The case of a multifacility falls reduction project. *Journal of Gerontological Nursing*, *39*(9), 24–30. https://doi.org/10.3928/00989134-20130627-02

Adams, W. C. (2015). Conducting semi-structured interviews. In K. E. Newcomer, H. P. Hatry, & J. S. Wholey (Eds.), *Handbook of practical program evaluation* (1st ed., pp. 492–505). Wiley. https://doi.org/10.1002/9781119171386.ch19

Alexander, C., Tschannen, D., Argetsinger, D., Hakim, H., & Milner, K. A. (2021). A qualitative study on barriers and facilitators of quality improvement engagement by frontline nurses and leaders. *Journal of Nursing Management*. https://onlinelibrary-wiley-com.proxy.bib.uottawa.ca/doi/full/10.1111/jonm.13537

Amaratunga, T., & Dobranowski, J. (2016). Systematic review of the application of Lean and Six Sigma quality improvement methodologies in radiology. *Journal of the American College of Radiology: JACR*, *13*(9), 1088-1095.e7. https://doi.org/10.1016/j.jacr.2016.02.033

Andrews, N., Gabbay, J., Le-May, A., Miller, E., Petch, A., & O'Neill, M. (2020). Story, dialogue and caring about what matters to people: Progress towards evidence-enriched policy and practice. *Evidence & Policy*, *16*(4), 597–618. https://doi.org/10.1332/174426420X15825349063428

Aplin, N. S. (2020). A day in the life of an advanced clinical practitioner in older people's care. *Nursing Older People*, *32*(5), 12–15. https://doi.org/10.7748/nop.2020.e1258

Ayanian, J. Z., & Markel, H. (2016). Donabedian's lasting framework for health care quality. *New England Journal of Medicine*, *375*(3), 205–207. https://doi.org/10.1056/NEJMp1605101

Aylesworth, G. (2015). Postmodernism. In E. N. Zalta (Ed.), *The Stanford Encyclopedia of Philosophy* (Spring 2015). Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/spr2015/entries/postmodernism/

Banerjee, A., Stanton, E., Lemer, C., & Marshall, M. (2012). What can quality improvement learn from evidence-based medicine? *Journal of the Royal Society of Medicine*, *105*(2), 55–59. https://doi.org/10.1258/jrsm.2011.110176

Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *Quality & Safety in Health Care*, *16*(1), 2–3. https://doi.org/10.1136/qshc.2006.022046

Berwick, D., Godfrey, A. B., & Roessner, J. (1990). *Curing Health Care*. Jossey-Bass.

Best, S. (1994). *Postmodernism and social inquiry* (1st ed.). Routledge. https://www-taylorfrancis-com.proxy.bib.uottawa.ca/reader/download/238e967b-193a-4a53-ab17-d9c80f29eb8e/chapter/pdf?context=ubx

Best, S., & Kellner, D. (1991a). Critical theory and postmodern Theory. In S. Best & D. Kellner (Eds.), *Postmodern Theory: Critical Interrogations* (pp. 215–255). Macmillan Education UK. https://doi.org/10.1007/978-1-349-21718-2_7

Best, S., & Kellner, D. (1991b). Foucault and the critique of modernity. In S. Best & D. Kellner (Eds.), *Postmodern theory: Critical interrogations* (pp. 34–75). Macmillan Education UK. https://doi.org/10.1007/978-1-349-21718-2_2

Bethel, C., Rainbow, J. G., & Dudding, K. M. (2021). Recruiting nurses via social media for survey studies. *Nursing Research*, *70*(3), 231–235. https://doi.org/10.1097/NNR.0000000000000482

Bianchi, M., Bagnasco, A., Bressan, V., Barisone, M., Timmins, F., Rossi, S., Pellegrini, R., Aleo, G., & Sasso, L. (2018). A review of the role of nurse leadership in promoting and sustaining evidence-based practice. *Journal of Nursing Management*, *26*(8), 918–932. https://doi.org/10.1111/jonm.12638

Burhans, L. M., & Alligood, M. R. (2010). Quality nursing care in the words of nurses. *Journal of Advanced Nursing*, *66*(8), 1689–1697. https://doi.org/10.1111/j.1365-2648.2010.05344.x

Cakiroglu, O. C., Hobek, G. U., & Harmanci Seren, A. K. (2022). Nurses' views on change management in health care settings: A qualitative study. *Journal of Nursing Management*, *30*(2), 439–446. https://doi.org/10.1111/jonm.13500

Canadian Association of Schools of Nursing. (2022). *National nursing education framework*. https://www.casn.ca/competency-guidelines/national-nursing-education-framework/

Canadian Nurses Association. (2019). *Advanced practice nursing: A pan-Canadian framework*. https://www.cna-aiic.ca/en/nursing/advanced-nursing-practice

Carnwell, R., & Daly, W. (2001). Strategies for the construction of a critical review of the literature. *Nurse Education in Practice*, *1*(2), 57–63. https://doi.org/10.1054/nepr.2001.0008

Celikates, R., & Flynn, J. (2023). Critical theory (Frankfurt school). In E. N. Zalta & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Winter 2023). Metaphysics

Research Lab, Stanford University. https://plato.stanford.edu/archives/win2023/entries/critical-theory/

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research*. SAGE Publications, Inc. https://sk-sagepub-com.proxy.bib.uottawa.ca/books/postmodern-and-poststructural-approaches-to-nursing-research

Cheek, J. (2004). At the margins? Discourse analysis and qualitative research. *Qualitative Health Research*, *14*(8). https://doi.org/10.1177/1049732304266820

Cheek, J., & Porter, S. (1997). Reviewing Foucault: Possibilities and problems for nursing and health care. *Nursing Inquiry*, *4*(2), 108–119. https://doi.org/10.1111/j.1440-1800.1997.tb00084.x

Cooklin, K. (2024, September 12). Foucault on Subjugated Knowledge and Emancipatory Aims. *ATINER CONFERENCE PRESENTATION SERIES No: PHI2024-0335*. ATINER.

Crowe, M. (2005). Discourse analysis: Towards an understanding of its place in nursing. *Journal of Advanced Nursing*, *51*(1), 55–63. https://doi.org/10.1111/j.1365-2648.2005.03461.x

Dean, M. (2010). *Governmentality: Power and rule in modern society* (2nd ed.). SAGE Publications, Inc.

Deschenes, S., & Kunyk, D. (2020). Situating moral distress within relational ethics. *Nursing Ethics*, *27*(3), 767–777. https://doi.org/10.1177/0969733019884621

Diaczun, T., & Miller, M. K. (2023). Nurse practitioner affecting systems change in the context of a LEADS leadership framework: Experience from the field. *International Nursing Review*, *n/a*(n/a). https://doi.org/10.1111/inr.12891

Donabedian, A. (2005). Evaluating the quality of medical care. *The Milbank Quarterly*, *83*(4), 691–729. https://doi.org/10.1111/j.1468-0009.2005.00397.x

Donald, F., Bryant-Lukosius, D., Martin-Misener, R., Kaasalainen, S., Kilpatrick, K., Carter, N., Harbman, P., Bourgeault, I., & DiCenso, A. (2010). Clinical Nurse Specialists and Nurse Practitioners: Title confusion and lack of role clarity. *Nursing Leadership*, *23*(SP2), 189–210. https://doi.org/10.12927/cjnl.2010.22276

Ericson-Lindman, E., & Strandberg, G. (2021). Change agents' experiences of implementing a new organizational culture in residential care for older people: A qualitative study. *Nordic Journal of Nursing Research*. https://journals-sagepub-com.proxy.bib.uottawa.ca/doi/10.1177/2057158521995994

Fairclough, N. (1992). Discourse and text: Linguistic and intertextual analysis within discourse analysis. *Discourse & Society*, *3*(2), 193–217. https://doi.org/10.1177/0957926592003002004

Felluga, D. (2015). *Critical theory: The key concepts*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=2028224

Fine, B., Golden, B., Hannam, R., & Morra, D. (2009). Leading Lean: A Canadian healthcare leader's guide. *Healthcare Quarterly*, *12*(3). https://www-longwoods-com.proxy.bib.uottawa.ca/content/20877/healthcare-quarterly/leading-lean-a-canadian-healthcare-leader-s-guide

Foucault, M. (1970). *The order of things*. Routledge. https://www-taylorfrancis-com.proxy.bib.uottawa.ca/books/mono/10.4324/9781315660301/order-things-michel-foucault

Foucault, M. (1972). *Archaeology of knowledge and the discourse on language* (A. Sheridan, Trans.). Pantheon Books.

Foucault, M. (with Foucault, M.). (1978). *The history of sexuality* (1st American ed.). Pantheon Books.

Foucault, M. (1979). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). Vintage Books.

Foucault, M. (with Gordon, C.). (1980). *Power/knowledge: Selected interviews and other writings, 1972-1977* (1st American ed.--). Pantheon Books.

Foucault, M. (1981). The order of discourse. In R. Young (Ed.), *Untying the text: A post-structuralist reader*. Routledge & Kegan Paul.

Foucault, M. (1982). The subject and power. *Critical Inquiry*, *8*(4), 777–795.

Foucault, M. (1984). *The Foucault reader* (P. Rainbow, Ed.; 1st ed). Pantheon Books.

Foucault, M. (1996). *Foucault live: Collected interviews, 1961-1984* (S. Lotringer, Trans.). Semiotexte.

Foucault, M. (with Bertani, M., Fontana, A., & Macey, D.). (2003). *"Society must be defended": Lectures at the Collège de France, 1975-76* (1st Picador pbk. ed.). Picador.

Foucault, M. (2005). The discourse on language. In D. Wood & J. Medina (Eds.), *Truth* (pp. 315–335). Blackwell Publishing. https://doi.org/10.1002/9780470776407.ch20

Frilund, M., Fagerstrøm, L., & Vasset, F. (2023). The challenges of change processes for nurse leaders: A qualitative study of long-term leaders' experiences over 25 years. *Nursing Open*, *10*(8), 5423–5432. https://doi.org/10.1002/nop2.1781

Garland, D. (2014). What is a "history of the present"? On Foucault's genealogies and their critical preconditions. *Punishment & Society*, *16*(4), 365–468. https://doi.org/10.1177/1462474514541711

Gaurav, P. K. (2021). Foucault, discourse, society and power. *Language In India*, *21*(10), 173–180.

Glenn, J. G. (2019). Governmentality, biopolitics and disciplinary mechanisms. In J. G. Glenn (Ed.), *Foucault and post-financial crises: Governmentality, discipline and resistance* (pp. 15–41). Springer International Publishing. https://doi.org/10.1007/978-3-319-77188-5_2

Greckhamer, T., & Cilesiz, S. (2014). Rigor, transparency, evidence, and representation in discourse analysis: Challenges and recommendations. *International Journal of Qualitative Methods*, *13*(1), 422–443. https://doi.org/10.1177/160940691401300123

Gutting, G., & Oksala, J. (2022). Michel Foucault. In E. N. Zalta & U. Nodelman (Eds.), *The Stanford Encyclopedia of Philosophy* (Fall 2022). Metaphysics Research Lab, Stanford University. https://plato.stanford.edu/archives/fall2022/entries/foucault/

Health Quality Ontario. (2020). *Anxiety disorders: Health Quality Ontario (HQO)*. https://www.hqontario.ca/evidence-to-improve-care/quality-standards/view-all-quality-standards/anxiety-disorders

Health Standards Organization. (2023). *Clinical governance*. https://healthstandards.org/standard/clinical-governance-can-hso-1003-2023-e/

Holloway, I., & Freshwater, D. (2007). *Narrative Research in Nursing*. Blackwell Publishing. https://onlinelibrary-wiley-com.proxy.bib.uottawa.ca/doi/book/10.1002/9781444316513

Hook, D. (2001). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *History & Psychology*, *11*(4). https://journals-sagepub-com.proxy.bib.uottawa.ca/doi/abs/10.1177/0959354301114006

Hoy, D. C. (with McCarthy, T.). (1994). *Critical Theory*. B. Blackwell.

Ingelsson, P., Bäckström, I., & Snyder, K. (2020). Adapting a Lean leadership-training program within a health care organization through cocreation. *International Journal of Quality and Service Sciences*, *12*(1), 15–28. https://doi.org/10.1108/IJQSS-09-2019-0107

Institute for Healthcare Improvement. (2003). *The Breakthrough series: IHI's collaborative model for achieving breakthrough improvement*. Institute for Healthcare Improvement. https://www.ihi.org/library/white-papers/breakthrough-series-ihis-collaborative-model-achieving-breakthrough

Institute of Medicine. (2001). *Crossing the Quality Chasm*. Institute of Medicine.

International Council of Nurses. (2020). *Guidelines on advanced practice nursing*. https://www.icn.ch/system/files/documents/2020-04/ICN_APN%20Report_EN_WEB.pdf

Keller, R. (2011). The sociology of knowledge spproach to discourse (SKAD). *Human Studies*, *34*(1), 43–65. https://doi.org/10.1007/s10746-011-9175-z

Kerr, D. (1999). Beheading the king and enthroning the market: A critique of Foucauldian governmentality. *Science & Society*, *63*(2), 173–202.

Kilo, C. M. (1998). A framework for collaborative improvement: Lessons from the Institute for Healthcare Improvement's breakthrough series. *Quality Management in Healthcare*, *6*(4), 1.

Kilpatrick, K., DiCenso, A., Bryant-Lukosius, D., Ritchie, J. A., & Carter, R. M.-M. and N. (2014). Clinical Nurse Specialists in Canada: Why are some not working in the role? *Nursing Leadership*, *27*(1). https://www-longwoods-com.proxy.bib.uottawa.ca/content/23738/nursing-leadership/clinical-nurse-specialists-in-canada-why-are-some-not-working-in-the-role-

Kilpatrick, K., DiCenso, A., Bryant-Lukosius, D., Ritchie, J. A., Martin-Misener, R., & Carter, N. (2013). Practice patterns and perceived impact of clinical nurse specialist roles in Canada: Results of a national survey. *International Journal of Nursing Studies*, *50*(11), 1524–1536. https://doi.org/10.1016/j.ijnurstu.2013.03.005

Kilpatrick, K., Tchouaket, E., Carter, N., Bryant-Lukosius, D., & DiCenso, A. (2016). Structural and process factors that influence Clinical Nurse Specialist role implementation. *Clinical Nurse Specialist*, *30*(2). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00002800-201603000-00008/PDF

Knight, S. (1998). A study of the 'lived' experience of change during a period of curriculum and organizational reform in a department of nurse education. *Journal of Advanced Nursing*, *27*(6), 1287–1295. https://doi.org/10.1046/j.1365-2648.1998.00654.x

Koyle, M. A., Koyle, L. C. C., & Baker, G. R. (2018). Quality improvement and patient safety: Reality and responsibility from Codman to today. *Journal of Pediatric Urology*, *14*(1), 16–19. https://doi.org/10.1016/j.jpurol.2017.07.004

Lambert, L. K., & Lauck, S. B. (2025). *Policy recommendations for optimizing the Clinical Nurse Specialist workforce in British Columbia*. BC Cancer Provincial Health Service Authority.

Larrabee, J., & Bolden, L. (2001). Defining patient-perceived quality of nursing care. *Journal of Nursing Care Quality*, *16*(1). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00001786-200110000-00005/PDF

Lemke, T. (2015). *Foucault, governmentality, and critique*. Routledge. https://doi.org/10.4324/9781315634609

Lewandowski, W., & Adamle, K. (2009). Substantive area of Clinical Nurse Specialist practice: A comprehensive review of the literature. *Clinical Nurse Specialist*, *20*(2). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00002800-200903000-00008/HTML

Locock, L., Parkin, S., Montgomery, C., & Chisholm, A. (2021, January 18). How frontline teams engage with patient-centred quality improvement. *Nursing Times*. https://www.nursingtimes.net/clinical-archive/patient-experience/how-frontline-teams-engage-with-patient-centred-quality-improvement-18-01-2021/

Luce, J. M., Bindman, A. B., & Lee, P. R. (1994). A brief history of health care quality assessment and improvement in the United States. *Western Journal of Medicine*, *160*(3), 263–268.

Lueg, K., Starboek Bager, A., & Wolff Lundholt, M. (2021). Introduction: What counter-narratives are: Dimensions and levels of a theory of middle range. In *Routledge Handbook of Counter Narratives* (1st ed.). Routledge. https://www-taylorfrancis-com.proxy.bib.uottawa.ca/reader/read-online/5d0788a5-adb9-4c9d-bbe1-f5443cefced3/chapter/pdf?context=ubx

Lyotard, J.-F. (1984). *The postmodern condition: A report on knowledge*. U of Minnesota Press.

Magadze, T. A., Nkhwashu, T. E., Moloko, S. M., & Chetty, D. (2022). The impediments of implementing infection prevention control in public hospitals: Nurses' perspectives. *Health SA Gesondheid*, *27*(0), Article 0. https://doi.org/10.4102/hsag.v27i0.2033

Mahon, M. (1993). Michel Foucault's archaeology, enlightenment, and critique. *Human Studies*, *16*(1–2), 129–141. https://doi.org/10.1007/BF01318575

Mandel, K. E., & Cady, S. H. (2022). Quality improvement as a primary approach to change in healthcare: A precarious, self-limiting choice? *BMJ Quality & Safety*, *31*(12), 860–866. https://doi.org/10.1136/bmjqs-2021-014447

Mason, S. E., Nicolay, C. R., & Darzi, A. (2015). The use of Lean and Six Sigma methodologies in surgery: A systematic review. *The Surgeon: Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland*, *13*(2), 91–100. https://doi.org/10.1016/j.surge.2014.08.002

McCannon, J., Schall, M., Calkins, D., & Nazem, A. (2006). Saving 100 000 lives in US hopitals. *British Medical Journal*, *332*.

McHoul, A., & Grace, W. (1993). *A Foucault primer: Discourse, power, and the subject*. Melbourne University Press.

McKinlay, A., & Pezet, E. (2019). Organizing Michel Foucault: Power, knowledge and governmentality. In *Management, Organizations and Contemporary Social Theory*. Routledge.

McMillan, K., & Perron, A. (2013). Nurses Amidst Change: The Concept of Change Fatigue Offers an Alternative Perspective on Organizational Change. *Policy, Politics, & Nursing Practice*, *14*(1), 26–32. https://doi.org/10.1177/1527154413481811

McMillan, K., & Perron, A. (2020a). Change fatigue in nurses: A qualitative study. *Journal of Advanced Nursing*, *76*(10), 2627–2636. https://doi.org/10.1111/jan.14454

McMillan, K., & Perron, A. (2020b). Ideological tensions amidst rapid and continuous organizational change in healthcare. *Journal of Organizational Change Management*, *33*(6), 1029–1039. https://doi.org/10.1108/JOCM-02-2020-0061

Migita, R., Yoshida, H., Rutman, L., & Woodward, G. A. (2018). Quality improvement methodologies. *Pediatric Clinics of North America*, *65*(6), 1283–1296. https://doi.org/10.1016/j.pcl.2018.07.011

Miller, S. (1990). Foucault on discourse and power. *Theoria: A Journal of Social and Political Theory*, (76), 115–125.

Mills, S. (2003). *Michel Foucault*. Routledge. https://doi.org/10.4324/9780203380437

Morrison, V. J., & Jensen, A. L. (2022). Between a rock and a hard place: Nurse managers' experiences of large-scale organizational change in the public health service. *Journal of Advanced Nursing*. https://onlinelibrary-wiley-com.proxy.bib.uottawa.ca/doi/10.1111/jan.15413

Moussa, M., & Scapp, R. (1996). The practical theorizing of Michel Foucault: Politics and counter-discourse. *Cultural Critique*, (33), 87–112. https://doi.org/10.2307/1354388

National Association of Clinical Nurse Specialists. (2004). Model rules and regulations for CNS title protection and scope of practice. *Clinical Nurse Specialist*, *18*(4). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00002800-200407000-00005/PDF

National Council of State Boards of Nursing. (2023). *CNS Independent Practice Map*. NCSBN. https://www.ncsbn.org/nursing-regulation/practice/aprn/aprn-consensus-implementation-status/cns-independent-practice-map.page

Ndawo, G. M. (2022). Nurse educators' experiences regarding management practices at a nursing education institution. *Health SA Gesondheid*, *27*(0), Article 0. (37-65 years; Males & Females). https://doi.org/10.4102/hsag.v27i0.1935

Nghe, M., Hart, J., Ferry, S., Hutchins, L., & Lebet, R. (2020). Developing leadership competencies in midlevel nurse leaders: An innovative approach. *JONA: The Journal of Nursing Administration*, *50*(9), 481. https://doi.org/10.1097/NNA.0000000000000920

Nixon, A., & Power, C. (2007). Towards a framework for establishing rigour in a discourse analysis of midwifery professionalisation. *Nursing Inquiry*, *14*(1), 71–79. https://doi.org/10.1111/j.1440-1800.2007.00352.x

Nola, R. (1994). Post-modernism, a French cultural Chernobyl: Foucault on power/knowledge. *Inquiry*, *37*(1), 3–43. https://doi.org/10.1080/00201749408602338

Ocloo, J., & Matthews, R. (2016). From tokenism to empowerment: Progressing patient and public involvement in healthcare improvement. *BMJ Quality & Safety*, *25*(8), 626–632. https://doi.org/10.1136/bmjqs-2015-004839

Oksuzyan, A., Höhn, A., Krabbe Pedersen, J., Rau, R., Lindahl-Jacobsen, R., & Christensen, K. (2020). Preparing for the future: The changing demographic composition of hospital patients in Denmark between 2013 and 2050. *PLoS ONE*, *15*(9), e0238912. https://doi.org/10.1371/journal.pone.0238912

Ontario Health. (2024). *Quality improvement plan guidance document 2025/26*. Ontario Health.

Ontario Health. (2025). *Ontario Health About Us*. Ontario Health. https://www.ontariohealth.ca/about

O'Sullivan, M. (2022). Effecting change and improving practice in a regional emergency department: A mental health Nurse Practitioner's perspective. *International Journal of Mental Health Nursing*, *31*(6). https://onlinelibrary-wiley-com.proxy.bib.uottawa.ca/doi/10.1111/inm.13054

Parry, G. (2014). A brief history of quality improvement. *Journal of Oncology Practice / American Society of Clinical Oncology*, *10*, 196–199. https://doi.org/10.1200/JOP.2014.001436

Perron, A., & Rudge, T. (2015). *On the politics of ignorance in nursing and health care: Knowing ignorance*. Taylor & Francis Group. http://ebookcentral.proquest.com/lib/ottawa/detail.action?docID=2166384

Polit, D., & Beck, C. (2021). *Nursing research: Generating and assessing evidence for nursing practice* (11th ed.). Wolters Kluwer.

Pyzdek, T. (2021). *The lean healthcare handbook: A complete guide to creating healthcare workplaces* (Second edition.). Springer. https://doi.org/10.1007/978-3-030-69901-7

Rasmussen, D. M., & Swindal, J. (2004). *Critical theory*. SAGE.

Registered Nurses Association of Ontario. (2023). *Transforming nursing through knowledge: Social movement of science*.

Roberts, M. (2017). Critical thinking and contemporary mental health care: Michel Foucault's "history of the present." *Nursing Inquiry*, *24*(2), e12167. https://doi.org/10.1111/nin.12167

Rose, N. (1993). Government, authority and expertise in advanced liberalism. *Economy and Society*, *22*(3), 283–299. https://doi.org/10.1080/03085149300000019

Rudge, T. (2013). Desiring productivity: Nary a wasted moment, never a missed step! *Nursing Philosophy*, *14*(3), 201–211. https://doi.org/10.1111/nup.12019

Ryder, M., Jacob, E., & Hendricks, J. (2020). An integrative review to identify evidence of nurse practitioner-led changes to health-care delivery and the outcomes of such changes.

International Journal of Nursing Practice, *26*(6), e12901. https://doi.org/10.1111/ijn.12901

Sakellariou, D., & Rotarou, E. S. (2017). The effects of neoliberal policies on access to healthcare for people with disabilities. *International Journal for Equity in Health*, *16*(1), 199. https://doi.org/10.1186/s12939-017-0699-3

Salmond, S. W., & Echevarria, M. (2017). Healthcare transformation and changing roles for nursing. *Orthopaedic Nursing*, *36*(1), 12–25. https://doi.org/10.1097/NOR.0000000000000308

Sampath, R. (1995). The historicity of archeaology: Historical time in Foucault's the order of things. *Symplokē*, *3*(2), 135–163.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, *16*(2). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00012272-199312000-00002/PDF

Schoales, C. A., Bourbonnais, F. F., & Rashotte, J. (2018). Building to make a difference: Advanced Practice Nurses' experience of power. *Research and Theory for Nursing Practice*, *32*(1), 96–116. https://doi.org/10.1891/1541-6577.32.1.96

Schroeder, P., Parisi, L., & Foster, R. (2019). Healthcare quality improvement: Then and now. *Nursing Management*, *50*(9). https://oce-ovid-com.proxy.bib.uottawa.ca/article/00006247-201909000-00006/PDF

Scoville, R., & Little, K. (2014). *Comparing lean and quality improvement*. Institute for Healthcare Improvement. https://www.ihi.org/resources/white-papers/comparing-lean-and-quality-improvement

Seh, A. H., Zarour, M., Alenezi, M., Sarkar, A. K., Agrawal, A., Kumar, R., & Ahmad Khan, R. (2020). Healthcare data breaches: Insights and implications. *Healthcare*, *8*(2), Article 2. https://doi.org/10.3390/healthcare8020133

Shannon, V., & French, S. (2005). The impact of the re-engineered world of health-care in Canada on nursing and patient outcomes. *Nursing Inquiry*, *12*(3), 231–239. https://doi.org/10.1111/j.1440-1800.2005.00272.x

Shortell, S. M., Bennett, C. L., & Byck, G. R. (1998). Assessing the impact of continuous quality improvement on clinical practice: What it will take to accelerate progress. *The Milbank Quarterly*, *76*(4), 593–624. https://doi.org/10.1111/1468-0009.00107

Solbakken, R., Bondas, T., & Kasén, A. (2020). First-line nurse managers' challenges at the crossroads of Norwegian health care reforms. *Nursing Administration Quarterly*, *44*(3), 205–214. https://doi.org/10.1097/NAQ.0000000000000420

Springer, R. A., & Clinton, M. E. (2015). Doing Foucault: Inquiring into nursing knowledge with Foucauldian discourse analysis. *Nursing Philosophy*, *16*(2), 87–97. https://doi.org/10.1111/nup.12079

Steinmetz, G. (2005). Introduction: Positivism and its others in the social sciences. In *The Politics of Method in the Human Sciences: Positivism and Its Epistemological Others*. Duke University Press. https://read-dukeupress-edu.proxy.bib.uottawa.ca/books/book/2082/chapter/242795/IntroductionPositivism-and-Its-Others-in-the

Steinskog, T.-L. D., Tranvåg, O., Nortvedt, M. W., Ciliska, D., & Graverholt, B. (2021). Optimizing a knowledge translation intervention: A qualitative formative study to capture

knowledge translation needs in nursing homes. *BMC Nursing*, *20*, 1–11. https://doi.org/10.1186/s12912-021-00603-5

Wagstaff, C. R. D., Gilmore, S., & Thelwell, R. C. (2015). Sport medicine and sport science practitioners' experiences of organizational change. *Scandinavian Journal of Medicine & Science in Sports*, *25*(5), 685–698. https://doi.org/10.1111/sms.12340

White, E. (2012). Challenges that may arise when conducting real-life nursing research. *Nurse Researcher*, *19*. https://doi.org/10.7748/nr2012.07.19.4.15.c9219

Wong, R. (2020). *A Foucauldian Discourse Analysis of diabetes knowledge translation and the governance of family physicians and endocrinologists in Canada* [Thesis]. https://tspace.library.utoronto.ca/handle/1807/101154

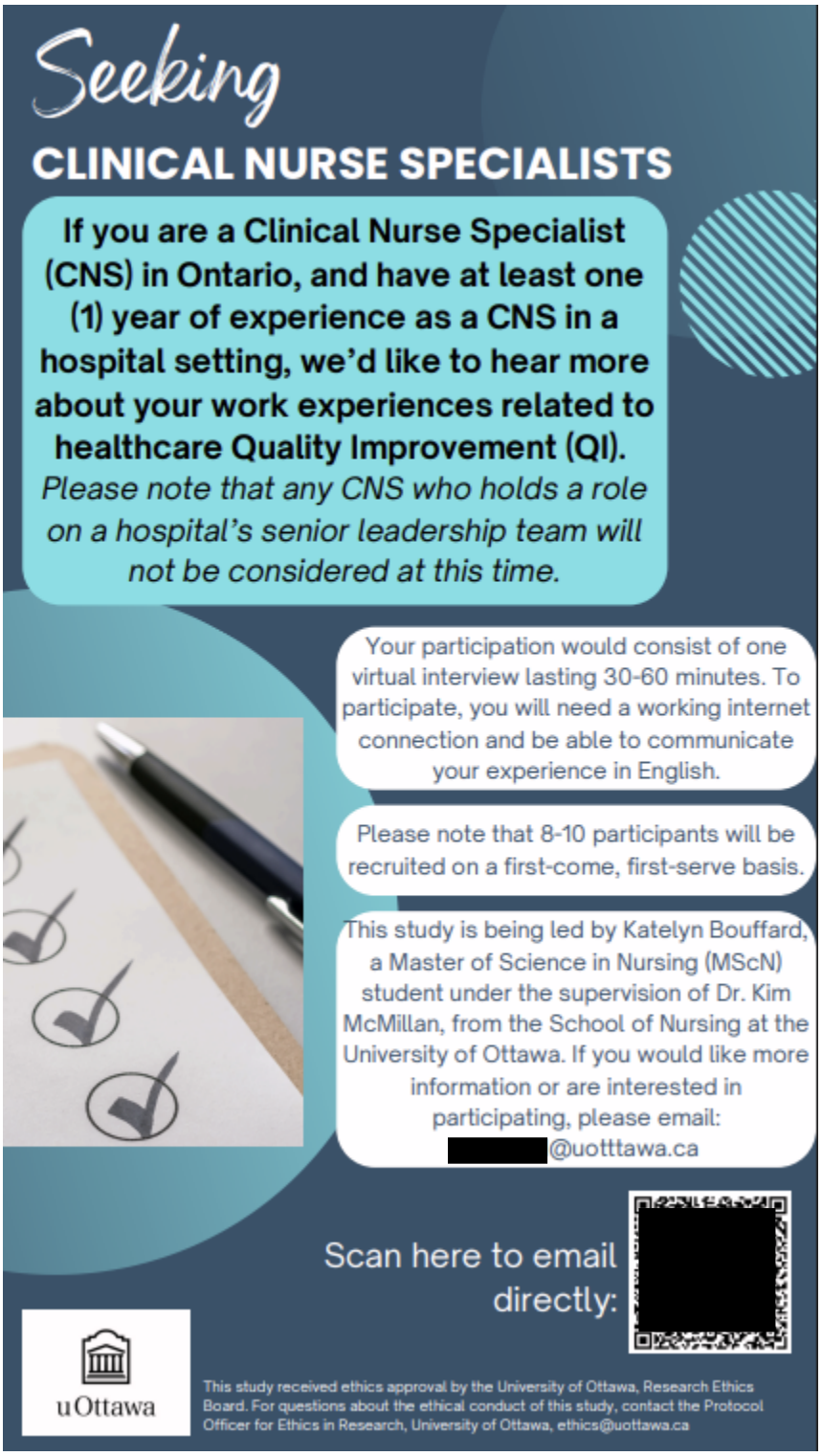
Worsley, C., Webb, S., & Vaux, E. (2016). Training healthcare professionals in quality improvement. *Future Hospital Journal*, *3*(3), 207–210. https://doi.org/10.7861/futurehosp.3-3-207

Yates, S., & Hiles, D. (2010). Towards a "critical ontology of ourselves"? *Theory & Psychology*, *20*(1), 5–143. https://doi.org/10.1177/0959354309345647

Young, M., & Smith, M. A. (2023). Standards and evaluation of healthcare quality, safety, and person-centered care. In *StatPearls*. StatPearls Publishing. http://www.ncbi.nlm.nih.gov/books/NBK576432/

Appendices

Appendix A: Recruitment Poster



Appendix B: Interview Guide

Katelyn Bouffard – APN FDA Interview Guide

1. Can you tell me about your education and background as an advanced practice nurse?
    a. Where did you study? When did you study? What inspired you to become an advanced practice nurse?
2. Was quality improvement work a part of your undergraduate or graduate nursing studies? If so, what was this experience like?
    a. Did you anticipate QI as a part of your undergraduate/graduate studies? Is this something you were personally inspired to do? Or was it a program requirement?
3. Can you tell me about your current job/role at your hospital?
    a. How do you engage in QI work?
    b. How much of your workload consists of QI initiatives?
4. Can you tell me a bit about what a previous QI project/experience looked like for you?
5. At your hospital, who decides what QI initiatives will be brought forward?
    a. Does hospital management and administration move drive QI initiatives, or are these projects brought forward by patient-facing, patient facing staff?
6. What kind of pressures do you think primarily drive QI initiatives at your hospital?
    a. Are they patient driven? Patient-facing nurse drive? Management driven? Driven by outside factors such as accreditation standards?
    b. Why do you think the dominant drivers of QI are what they are?
7. How would you define success of a QI project?
    a. Is success in peoples' (nurses, patients) experiences? Or is success defined by numbers and statistics?
8. In your experience, are QI projects successful?
    a. If so, what makes them successful? If not, what are the barriers to their success?
9. If projects are not successful, who is blamed for that?
    a. Does the blame fall on management, on the APNs and other professionals implementing the project, or on the patient-facing nurses and patient-facing staff?
10. What kind of language is used to describe the failures of QI?
    a. If the failures are blamed on patient-facing nurses, how are patient-facing nurses described in a situation of QI failure?
    b. What kind of language is used to describe the failures?
11. Do you personally connect with the QI work that you do? Do you find it meaningful?
12. Do you think the patient-facing staff find the QI work at the hospital meaningful? Do they connect with it?
    a. If not, how would you describe their views on QI work?
13. Is there anything we haven't addressed that you think would be important for me to know?

Appendix C: Informed Consent Document

uOttawa

Université d'Ottawa
Faculté des sciences de la santé
École des sciences infirmières

University of Ottawa
Faculty of Health Sciences
School of Nursing

INFORMED CONSENT DOCUMENT

Quality Improvement in Healthcare: A Foucauldian Discourse Analysis Examining through the lens of Advanced Practice Nurses

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Researchers' Statement: We invite you to participate in a research study. The purpose of this form is to give you the information you will need to help you decide whether to be part of the study or not. Please read this form carefully. You may ask questions about the purpose of this research, what we ask you to do, the possible risks and benefits of participating, your rights as a participant and anything else about the research or this form that is not clear by contacting Katelyn Bouffard, MScN student, at the email address given above. You should keep this form for your records.

Background Information: The purpose of this research is to explore the perspectives and experiences of Advanced Practice Nurses (NPs and CNSs) working in hospital settings in Canada as they relate to quality improvement (QI) in healthcare. We are particularly interested in exploring the experiences and challenges that APNs face in their professional roles as it relates to QI in healthcare organizations.

Procedures: If you agree to be a participant in this research study, we will ask you to participate in one interview. All interviews will be conducted virtually via Microsoft Team, a virtual meeting platform that provides both audio and video. Interviews will be audio recorded for analysis purposes. We anticipate the interview will last between 30 and 60 minutes about.

Eligibility: You are eligible to participate in this study if you are a Canadian Advanced Practice Nurse (APN) (Nurse Practitioner or Clinical Nurse Specialist) who 1) has a graduate degree in nursing and

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2) currently or previously worked in a hospital-based setting as an APN. You are not eligible for this study if you currently hold a position of senior leadership (i.e. Chief Nursing Executive, Director role) in a hospital setting.

Risks and Benefits to Being in the Study: Your participation will involve talking about your experiences as an APN as it related to QI work and initiatives in healthcare. You may experience emotional discomfort during these conversations as they are of a sensitive nature. If you feel uncomfortable during the interview, we can stop at any time. You may choose to continue with the interview, reschedule it, or withdraw from the study. We will debrief at the end of our meeting. There is also a risk of negative social repercussions for you if the comments you make in the context of this study become known, either to your employer, or within your professional community. However, please note, this project is being conducted independently from the organizations and agencies from which participants may be recruited. We will keep everything you tell us strictly confidential. We will not keep any record of who your employer is, and your identity as a research participant will not be known to anyone outside of the research team. It is up to you whether or not you choose to disclose to others that you are participating in this study. Potential benefits to being in this study include the opportunity to reflect on your perspectives and experiences about this topic. There is also a potential benefit to the nursing community in studying perspectives and experiences relating to QI in healthcare.

Compensation: There is no compensation for participating in this study.

Confidentiality and Privacy: The records of this research study will be kept private and confidential. All research records, including audio recording and transcripts will be kept on a password secured computer in the home offices of the principal investigators. Access will be limited to the researcher and their supervisor. All data (digital recordings, paper and electronic copies of the researchers' notes, and transcribed interviews) will be kept securely, stored in password protected electronic files for at least five years. After this period, the data may be destroyed. This will be done securely through secure deletion. Data will be anonymized, in that numerical codes will be assigned to all participants; your name will not appear on any data relating to this study. Any and all dissemination of data in the form of presentations, webinars or scholarly publications will only include assigned numeric codes. All potentially identifying information will not appear in any dissemination materials.

Voluntary Nature of the Study: Your participation is voluntary. If you choose not to participate, it will not affect your current or future relations with the University or anyone associated with this project. There is no penalty or loss of benefits for not participating or for discontinuing your participation. You may choose to withdraw your participation from the study at any time. Should you choose to discontinue your participation after the interview has taken place, your interview data be promptly destroyed.

Contacts and Questions: The researcher responsible for this research is Katelyn Bouffard. You may ask any questions you have now. If you have any questions later, you may contact the researcher at the contact information indicated on page one (1). If you have questions regarding the ethical conduct of this study, you may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa,

ON K1N 6N5; Tel.: (613) 562- 5387. Or by e-mail at ethics@uottawa.ca [1]
[1] During University closures related to the pandemic, e-mail is the best way to reach the Protocol Officer

Statement of Consent

(To be obtained verbally and audio-recorded immediately prior to the interview.) Name

of Participant _____ Date: _____

"I have read the above information. I have received answers to the questions I have asked. I am aware that my interview is being recorded. I consent to participate in this research. I understand that my participation is voluntary and that I can withdraw at any time."

Participants should keep a copy of this form for their personal records. If you wish, you can write your name/date on the lines above for your own records, but you do not need to send this form back to us.

Appendix D: REB Certificate of Approval

29/04/2024

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	H-04-24-10277
Titre du projet / Project Title	Quality Improvement (QI) in Healthcare: A Foucauldian Discourse Analysis Examining QI through the lens of Advanced Practice Nurses
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	29/04/2024
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	28/04/2025

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Katelyn BOUFFARD	École des sciences infirmières / School of Nursing	Chercheur Principal / Principal Investigator
Kim MCMILLAN	University of Ottawa	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

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