ORGANIZATIONAL AGENTS AS EPISTEMIC AGENTS: RE-EXAMINING NURSE EXECUTIVES' AGENCY IN HOMECARE ORGANIZATIONS

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Preface

This doctoral thesis is my original, independent work. Chapter 1 addresses my motivation to conduct this research and gives an overview of my philosophical stance. It also discusses my research's purpose, significance and research design. In the second chapter, I provide a literature view focusing on nurse executives in homecare organizations and healthcare in Canada. Chapter 3 explores how I used Critical Management Studies, as informed by Foucault, and the Sociology of Ignorance to create a novel theoretical framework. It is a published manuscript, where I am the first author: Ashley, L. & Perron, A. (2023). Examining the role of nurse executives in homecare through the lens of the Sociology of Ignorance and Critical Management Studies. *Nursing Philosophy*, e12445. I was responsible for the writing of the article. Dr. Perron was the advisor and participated in the article composition. Chapter 4 describes my use of Fairclough's Critical Discourse Analysis for data collection and analysis. I also address methodological rigour, reflexivity, and ethical considerations. In Chapter 5, I present the results of my research and then connect the results to empirical literature and my theoretical framework in Chapter 6. This doctoral thesis is a hybrid approach that combines a monograph with five conventional chapters and Chapter 3 in the form of a published article.

I hope you enjoy reading my thesis.

Lisa Ashley

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Abstract

This research presents a critical analysis and original theoretical approach to a complex phenomenon that addresses current gaps in our understanding of the experiences of nurse executives and their organizational positioning in homecare organizations. It reveals how nurse executives experience paradoxical identities of executive and nurse. The competitiveness of homecare as a business and the status of homecare among other healthcare sectors is problematic and exacerbates the tension between those two identities. This qualitative research aims to explore NEs' epistemic and discursive organizational positioning in HCOs. This research also explores how nurse executives enact their moral, socio-professional, political and epistemic agency in homecare organizations in Ontario. The research questions guiding this study were: 1) How do nurse executives enact their agency, identity, values, and means in their organization? 2) What are the daily transactions and negotiations with organizational and systemic entities with which nurse executives engage in their organization? 3) How do nurse executives navigate such complexities to fulfil their organizational responsibilities and enact influence in their organizations? This research emphasized the importance of dominant discourses and practices in homecare organizations, shaping distinct epistemic landscapes that foster specific ways of thinking, speaking, and acting across those organizations and within the healthcare system. Fairclough's Critical Discourse Analysis was used to analyze interviews with nurse executives and selected policy and guidance documents. A theoretical framework combining Critical Management Studies, as informed by Foucault, and the Sociology of Ignorance was used to highlight the complexity of nurse executive power within the context of social structures. This study exposed the relationships and the circulation of knowledge and non-knowledge (i.e.,

ignorance) and the ability to exercise power within homecare organizations. Findings can contribute to scholarly knowledge about practice, education, policy, theory, and future research perspectives. This research has implications for scholarship about nursing leadership across healthcare and management disciplines by better understanding the power, knowledge, and ignorance dynamics within homecare organizations and the healthcare system.

Keywords: nurse executive, homecare, agency, identity, Sociology of Ignorance, Critical Management Studies, Critical Discourse Analysis

List of Acronyms and Abbreviations

ACN – Australian College of Nursing

CASE RNs - Canadian Association of Self-Employed Registered Nurses

CDA – Critical Discourse Analysis

CEO – Chief Executive Officer

CHCA - Canadian Home Care Association

CHNC - Community Health Nurses of Canada

CMS – Critical Management Studies

CNA – Canadian Nurses Association

CNE – Chief Nursing Executive

CNO – Chief Operating Officer

COVID-19 - Coronavirus global pandemic

EHR - Electronic Health Record

HCO - Homecare Organization

ICN – International Council of Nurses

KPI - Key Performance Indicator(s)

LPN – Licensed Practical Nurse

NE – Nurse Executive

RN – Registered Nurse

RNAO - Registered Nurses' Association of Ontario

RPN – Registered Practical Nurse

SOI - Sociology of Ignorance

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Chapter 1: Introduction

Homecare[1] organizations (HCOs) are complex social structures that organize people, healthcare[2] professionals and administrators in distinct ways (Romanow, 2002; Sharkey et al., 2003). HCOs provide a variety of health and support programs and services in the home and other community settings that assist people in recovering from acute medical conditions, living in the community with chronic illnesses, rehabilitating from illnesses, and receiving end-of-life care (Canadian Home Care Association, [CHCA] 2017; Romanow, 2002). While various terms, i.e., patient, client, and consumer, are used in Canada to describe people receiving homecare services, the term 'people' is mainly used throughout this thesis, except when participants are quoted directly. I use the term people as the other terms connote a biomedical or business model.

HCOs are understood to provide services and programs that "include assessments, education, therapeutic interventions, personal assistance with daily living activities, help with instrumental activities of daily living and carer respite and support." (CHCA, 2017, p.1) Nurse Executives (NEs)[3] are understood for my research as the highest-level administrative nurse in HCOs. They are Registered Nurses (RNs) responsible for overseeing both administrative (i.e., operational budgets) and clinical nursing functions (i.e., nursing personnel, care of people,

[1] For this research, the following spelling is used: homecare.

[2] For purposes of this research, the following spelling is used for these terms: Health care (two words) to refer to a provider's actions; Healthcare (one word) to refer to a system.

[3] The conceptualization of NEs is discussed in chapter 2.

technological innovations, and new models of care). Nurse Practitioners, RNs, and Registered Practical Nurses (RPNs)[4] provide homecare nursing[5] services focusing on "disease prevention, rehabilitation, restoration of health, health protection & promotion" in people's homes and other community settings (Community Health Nurses Canada [CHNC], 2010, p.7).

My career as an RN has impacted my journey to conduct this research. After two years in acute care, I specialized in community health nursing, focusing on practice, policy, education, and research in homecare and public health. For a decade as a Senior Nurse Advisor at the Canadian Nurses Association [CNA], I led the advancement of community health nursing in the Canadian healthcare system, advocating for healthy public policy and overseeing national nursing professional development, accreditation and nursing leadership programs. My interest in nursing leadership has been longstanding. I became aware of the constant healthcare changes affecting RNs, especially at the executive level in the community health sector. I saw nurse leaders being replaced by non-nurses. Nursing leadership positions would be eliminated because other healthcare providers did not have an executive lead in organizations. I found that such decisions go against accepted evidence regarding the significant benefits of instituting and promoting formal nursing leadership positions.

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[4] In Ontario, the term Registered Practical Nurse (RPN) is used as compared to the rest of Canada, which uses the term Licensed Practical Nurse (LPN) (National Nursing Assessment Service, 2023).

[5] Homecare nursing is used in this thesis as the research participants most often used that term.

In my work at CNA, I saw some nurses flourish and others struggle in their positions as executives in HCOs. Through conversations with NEs in HCOs, I became aware that despite having expertise in multiple practice, administration, and policy areas, some NEs described their knowledge, capacities, and abilities as underused, resisted, and ignored. They revealed situations whereby NEs in acute care settings, other executives in HCOs, and government officials did not understand the clinical and operational complexity of the NE role in homecare. Nor did acute care NEs, HCO executives, or government officials acknowledge the power dynamics and organizational discourses circulating within HCOs and the healthcare system. Some NEs I spoke with had left their positions as executives in HCOs, moving to positions that did not focus on nursing services. Others considered leaving, and some left to start businesses.

In comparison, other NEs I talked to were thriving in executive positions. They described being included in critical decision-making. They spoke about not compromising and being acknowledged for their knowledge and expertise. Those NEs felt immersed in an organizational culture inclusive of nursing. In all situations, however, NEs expressed tension between their nurse and executive identity. I wondered whether and how these identities can effectively exist in harmony within the NE role. I questioned the structures and processes within HCOs that influence this dual identity. I more critically questioned how NEs can enact their agency, which, for purposes of this research, is defined as a person's actions, which may be intentional or not, are influenced by the person's self-awareness, social and political structures, and actively stimulate change (Ahearn, 1999; Krause, 2015; Leeb, 2017; Maiguashca & Marchetti, 2013).

1.1 Purpose of the Study

In this study, HCOs are considered discursive, epistemic spaces where certain kinds of knowledge are deemed legitimate and others less so (Douglas, 1986; McGregor, 2001). The

epistemological arrangements in HCOs govern how information, expertise and discourses flow, create, and maintain subject positions, as well as incongruencies between ideals of performance and the organizational distribution of resources, authority, responsibility, and accountability (McGoey, 2007; Townley, 2011). These epistemological arrangements predetermine interactions between organizational agents whose status and influence hinge on their access to and strategic management of competing forms of knowledge (Reider, 2016).

This qualitative research aims to explore NEs' strategic epistemic and discursive positioning in HCOs. It explores how organizational enactment[6] of NE positions is mediated by overt and covert power, knowledge and ignorance dynamics that are socially, historically, and politically entrenched.

For this study, NEs are considered epistemic agents in the epistemic spaces of HCOs. Reider (2016) describes epistemic agency as a person's choices and actions based on their knowledge and how they use it. Epistemic agency can also rest on knowledge held but not valued by the collective or those who hold power. While organizations do not have agency, people create roles, practices, and discourses. Consequently, individuals who work within those organizational spaces conform to those codes and rules which influence individual agency (Deleuze, 2017).

NEs experience paradoxical identities and agency of executive and nurse in HCOs. The complexity and competitiveness of homecare as a business and the status of homecare among

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[6] The complexity of managing homecare is discussed in Chapter 2.

other healthcare sectors are problematic and exacerbate this tension. Tensions arise from living with two sets of values and knowledge (e.g., nursing and management) and conflicting organizational roles and responsibilities that may converge or conflict.

NEs often experience contradictions about how powerful their voice can be and how much influence they can exert (Jones et al., 2008; Jones-Berry, 2016; Kelly et al., 2016; Lúanaigh & Hughes, 2016). NEs contend with multiple discourses in the HCO (i.e., corporate, nursing, ethical, and legal), managing various sets of needs, interests and priorities which may or may not align with their nursing values (Boston-Fleischhauer, 2016; Lúanaigh & Hughes, 2016; Roberts, 1997). For example, NEs understand the need for nursing care in the home for individuals with increased frailty and co-morbidities. However, bringing this knowledge to other HCO executives may be challenging due to ideological tensions between care and service (O'Connor, 2017). A dearth of literature illustrates the context of what NEs experience in HCOs. Therefore, it supports the purpose of this study to understand the processes and patterns within organizations that mediate NEs' organizational lives.

Researchers have yet to examine the contrived imbalance of knowledge and ignorance that maintains the current power arrangements in HCOs, directly impacting NEs' enactment of agency. While nursing and sociological analyses have examined nurses at the bedside and in middle management positions and the interprofessional dynamics between health care professionals, limited research has explored the discursive, epistemic, and power transactions occurring at the executive level through NEs' strategic organizational positioning.

1.2 Research Aim and Questions

This study explored how NEs enact their moral, socio-professional, political and epistemic agency in HCOs in Ontario. The research questions guiding this study were:

1. How do NEs enact their agency, identity, values, and means in their organization?
2. What are the daily transactions and negotiations with organizational and systemic entities with which NEs are engaged in their organization?
3. How do NEs navigate such complexities to fulfil their organizational responsibilities and enact influence in their organizations?

1.3 Philosophical Foundation

This research is grounded in my epistemological position as a critical theorist viewed through a feminist lens. This approach supports a relativist ontology, where reality for the individual can have multiple interpretations, is contextually dependent and is based on how a person understands and interprets a phenomenon at a specific time. Such an understanding of reality supports a subjectivist epistemology, whereby knowledge is positioned as socially constructed through interactions with an analysis of one's environment (Guba & Lincoln, 1994).

Healthcare and nursing are politically and socially mediated, wherein individuals, such as NEs, are affected by many realities that may have multiple interpretations. For example, phenomena experienced by NEs in HCOs can be interpreted as problems stemming from the individual NEs themselves, i.e. a lack of skill, preparation, insight, or leadership, or as products of systemic yet obscured power and knowledge arrangements. Nursing leadership research is often situated within a positivist or post-positivist approach, focusing on objectivity, controlled variables, and conditions (Guba & Lincoln, 1994). These paradigms focus on causal relationships and a universal reality, which overlooks the complexity of the context in which NEs are situated.

My career has always been one of questioning healthcare practices and policy. As a community health nurse, my knowledge integrates multiple ways of knowing, including creativity, experiential knowledge, personal values, ethics, and placing myself within the broader

socio-political context (Stamler et al., 2020). Coming into the doctoral program, I questioned the post-positivist paradigm I was immersed in for most of my nursing career. My research required a critical, inductive theoretical approach, looking for clarity in concepts that were not static but fluctuating (Campbell & Wasco, 2000).

A critical theory framing for this study allows for the exploration of, engagement with, and reflection on power, knowledge and ignorance. A theoretical framework is a construct used to articulate the relationships between and amongst various concepts (Meleis, 2012). Theoretical frameworks propose ontological positioning that mediates how realities and phenomena can be interpreted and understood (Beckstead & Beckstead, 2006; Kuhn, 2012). Additionally, epistemological attributes consider the nature of the relationships between the knower and what can be known (Guba & Lincoln, 1994).

The value of a feminist lens in my research was to expose the voices of the NEs. I looked at the dimensions of social life, social inequity, and social transformation impacting the NEs' subjective positions and experiences within their social contexts. While I did not specifically affix my research to feminist theory, I did conceptualize a feminist lens and how it shaped my analysis and findings. I questioned traditional notions of domination, inequities, and cultural and social structures that allow awareness of women's position in nursing and HCOs (Caroselli, 1995; Fletcher, 2006; Klostermann et al., 2022). I considered the inquiry of power, knowledge and ignorance through a feminist, in particular through the works of key scholars such as Linsey McGoey (2007) and Chris Weedon (1997).

Using a SoI approach explicitly grounded in feminist thought (McGoey, 2019; Perron & Rudge, 2016) allowed me to expose the complexities in the (epistemic) division of labour in HCOs. I captured the diversity of the NE's experiences and explored their manifestations of

power. The lens of gender was embedded in the discourses within the HCOs that govern particular orientations such as ‘care’ and ‘business’.

This study makes a unique contribution using a theoretical framework spanning nursing, management, and sociology. I combine Critical Management Studies (CMS), as informed by Foucault, and the Sociology of Ignorance (SoI). This novel theoretical framework explicitly examines NEs’ strategic organizational positioning within HCOs’ power structures. It creates a useful framework for unpacking the complex interplay between knowledge and ignorance concerning NEs’ epistemic positioning. I use CMS and the SoI to examine these relationships and how they shape discursive practices, subjectivity, and the organizational positionality of NEs. These approaches explicitly acknowledge organizations as epistemic spaces, a novel perspective in organizational theorizing. The purpose of using CMS and the SoI is to identify and articulate critical ideas about the positioning of NEs in HCOs more completely and astutely.

From a methodological perspective, I use Fairclough’s (2013) Critical Discourse Analysis (CDA). Specifically, I use Fairclough’s (2013) CDA framework, which focuses on examining structures and events within social processes within an interdisciplinary framework (Fairclough, 2013). This reflective and critical methodological approach allows researchers to analyze semiotic relations between discourse and social structures, problems, ideologies, and identities, focusing on issues related to power and knowledge in HCOs (Fairclough, 2013; Wodak & Meyer, 2016). I use CDA to analyze the complex knowledge, non-knowledge, and multiple discourses circulating in HCOs. CDA facilitates understanding discourses in society and how discourse organizes social relations in various social spaces (Fairclough, 2013; Wodak & Meyer, 2016).

1.5 Significance of the Study

Through the use of CMS, the SoI, and Fairclough's CDA, this research can support the further development of nursing knowledge with particular attention to NEs' unique and complex realities. This study highlights the systemic and organizational interplay of knowledge, power and ignorance that must be exposed in HCOs for the nursing profession to understand what it is in organizations that configure power, voice and agency. It can enhance disciplinary knowledge by better understanding the power relationships within which NEs are embedded. These institutional and systemic power dynamics remain largely concealed and unchallenged. My study's significance lies in its contribution to nursing scholarship in research, policy, theory, education, and nursing practice. Approaching this research with NEs, a product of various social, professional, and organizational systems, contributes to nursing literature and sets the stage for a different understanding of nurses in executive positions, providing new ways to support NEs. The notion of agency in my research provides fresh knowledge of traditional nursing leadership literature. It may also serve as a valuable foundation for nursing education and professional development nursing programs. This critical qualitative research also makes a unique contribution theoretically, as CMS and the SoI are not well known in nursing and have never been used together in nursing research.

Chapter 2: Literature Review

A preliminary review of published peer-reviewed journals, periodicals, books, monographs, and grey literature from 1962 - 2021 was conducted to understand the depth and breadth of research on NEs in HCOs. Keywords used for the search included *nurse executive, chief nurse, senior nurse, nurse leader, leadership, agency, healthcare, homecare, identity, organization, organizational behaviour, epistemology,* and *governance*. This encompassed literature in healthcare, management and business databases and thesis/dissertations, including the Cumulative Index for Nursing and Allied Health Literature (CINAHL), OVID, ProQuest, PubMed (Medline), Longwoods Publishing, Business Source Complete, ABI/INFORM Complete (business journals database). Inclusion criteria included full texts, commentaries, guidance and policy documents, and media articles in the English language from countries with healthcare models similar to Canada's, including the United States, the United Kingdom, Scandinavia, Australia, and New Zealand. Due to the lack of existing scholarship in the homecare sector and nurses in executive positions in homecare, I had to look more broadly at literature from the acute care sector and healthcare in general.

An investigation of policy and guidance documents from national and international nursing organizations, HCOs, and health policy websites was searched to capture the historical and current context of NEs in all healthcare sectors. Based on more than two decades in leadership positions, my knowledge supplemented the literature related to NEs and homecare. A review of theoretical and methodological literature on *critical theory, feminist scholarship, critical management studies, power, knowledge, discourse, critical discourse analysis, and ignorance* provided this study's theoretical and methodological underpinnings.

This chapter is organized into three main sections. The first section focuses on how homecare is situated within Canada and the implications of neoliberalism on the management of homecare services. The second section describes NEs in homecare and the unique challenges in HCOs that mediate tensions. The third section offers a rethinking of the current framing of NEs through a critical lens. It includes a review of the literature on moral, political, and socio-professional agency.

Due to the publication of my article (Ashley & Perron, 2023), a variety of concepts that one would expect in this chapter are found in Chapter 3. These include the delineation of NEs in HCOs, HCOs as epistemic spaces, epistemic agency, ignorance, knowledge, and power, and the complexity of organizational enactment of NEs positions.

2.1 Neoliberalism in Canadian Healthcare

Compared to other international countries, Canada ranks as one of the lowest in performance in primary healthcare principles as defined in the Declaration of Alma-Ata (Moir & Barua, 2022; World Health Organization, 1978), which include high-quality health reform, improved access to care, public participation, and intersectoral collaboration. Consequently, healthcare is strongly emphasized on healthcare as a business and inequitable distribution of all levels of healthcare services, especially those provided in the home and community (Romanow, 2002; Sharkey et al., 2003; Yakerson, 2019).

This focus on healthcare as a commodity has resulted in health inequities, increased social exclusion, and an inability to access equitable healthcare (Polzer, 2016). This is highly noticeable in the homecare sector, where the number of hours for funded regulated nursing care, personal support, diagnostic tests, and equipment rental is significantly low, with resulting reliance on families to provide care and financial support (CHCA, 2008; Coyte & McKeever,

2001). While Canada captures healthcare spending data for hospitals, physicians, and drugs, it does not provide data specific to homecare. The Canadian Institute for Health Information [CIHI] (2023) indicates that in 2022, 6.1 percent of Ontario's healthcare funding went toward home and community care[7]. Considering the vast array of services this funding covers, it is reasonable to assume that the amount that covers homecare services is minimal.

This then brings in the concept of neoliberalism, which is based on the principles of "individualism, free market via privatization and deregulation, and decentralization" (McGregor, 2001, p.1). Neoliberalism is situated across all public and private healthcare organizations where consideration of how economics adversely influences health outcomes is not a priority (Labonté, 2020; Romanow, 2002). Scholars from various disciplines have argued that the hierarchal structures, primarily based on the biomedical model, structure, inform, and govern HCOs (Canadian Nurses Association [CNA], 2012; CNA, 2017; Romanow, 2002). The biomedical model, as empirical knowing, is only one way of knowing (Carper, 1978); however, it supersedes all other ways of knowing in the broader healthcare context where important decisions are made (England et al., 2007).

Homecare services are not insured under the *Canada Health Act* (Lanoix, 2017; Romanow, 2002). Therefore, HCOs must function as businesses within a neoliberal discursive

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[7] Home and community care in Ontario includes various services, including homecare, long-term care, supportive living in the community, child and youth services, and mental health and addictions (Home and Community Care Support Services. (2023).

frame approach to healthcare, with a higher private-to-public sector funding ratio than other healthcare systems (McGregor, 2001; Woolhandler et al., 2003). In effect, homecare is set up as a commodity to be purchased rather than a healthcare service covered by Canadian tax dollars (England et al., 2007). The governance and organization of homecare by the Ontario provincial government are complex. Fourteen geographically based organizations coordinate homecare services in Ontario (Home and Community Care Support Services, 2023). In 2022, the Ontario government restructured the delivery of homecare services. The 28 geographically based Local Health Integration Networks (LHINs) were reduced to 14 Home and Community Care Support Services organizations[8]. These organizations manage contractual service agreements with HCOs in their designated geographical areas. In addition to homecare, these organizations oversee other community-based services and long-term care.

People can self-refer or have someone refer them to Home and Community Care Health Services for homecare (Home and Community Care Support Services, 2023). Case coordinators then determine if a person is eligible for homecare, and what services they can receive. These organizations contract HCOs, private businesses and not-for-profit charitable organizations to provide nursing and other care to people in their homes. Consequently, the government requires HCOs to bid for contracts and receive partial government funding.

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[8] Home and Community Care Support Services (2023) are Crown agencies accountable to the Ministry of Health, Ministry of Long-Term Care and Ontario Health.

People in Canada are living longer and prefer to age and die at home while receiving complex, timely and skilled homecare nursing to recover from illness or injury and manage chronic diseases (Ganann et al., 2019; Romanow, 2002). Despite this articulated need for homecare, there is a projected increase in the need for nurses in homecare and other healthcare sectors (Stonebridge & Hermus, 2017). In 2022, there was a five percent decline in RNs employed in HCOs, with a six percent increase in RNs who were self-employed or working in private nursing agencies (CIHI, 2023). Cost-containment measures result in nursing care in the home being provided by other levels of regulated nurses and personal support workers who are not educated to provide care to people with multiple morbidities and complex health care needs (CNA, 2013). This creates challenges for NEs, which will be discussed in the following sections and Chapter 3.

2.2 NEs in Homecare

The historical roots of nursing and nurses have been well documented (Donahue, 1985; Egenes, 2017; Gibbon, 1947; Helmstadter, 2002; Moiden, 2002). However, besides a historical overview of the Victorian Order of Nurses in Canada (Hardill, 2007), little documentation traces the history of the NE's role in HCOs in Canada. Limited research has looked at the functions of NEs in HCOs beyond their management of staff nurses at the point of care in the home. Most of the published literature that examines the NE role is related to hospital settings. Consequently, in this chapter, I will often discuss NEs in healthcare organizations across all sectors of the healthcare system.

These gaps in the literature are interesting as they identify an entire area of nursing research that has been neglected over the years, further justifying this study. This dearth of international and Canadian scholarly literature about homecare and explicitly concerning the role

of the NE in HCOs may reflect that the limited number of HCOs compared to hospitals is systemic. This area of inquiry may also not be robust due to an assumption that whatever applies to NEs in the acute care sector probably applies to NEs in other healthcare sectors, including homecare. This is reflected in the generic language used in policy and guidance documents written by nursing associations (CNA, 2009; International Council of Nurses [ICN], 2022; RNAO, 2011). There may be a systemic forgetting of the field of homecare nursing.

In the nineteenth and twentieth centuries, the role of the NE was a position of influence, usually filled by women of higher social standing (Hawkins, 2010; Wildman & Hewison, 2009). This NE, or matron as it was called in the United Kingdom, had the specific responsibility of overseeing a hospital's nursing and housekeeping staff (Frederickson & Nickitas, 2011; Gilmartin, 1996). While NEs oversaw the entire facility's operations, they reported to a male head administrator (Wildman & Hewison, 2009). Many nursing scholars recognize that neoliberalism is predicated on specific gender roles that are highly defined along gendered lines (McGregor, 2001; O'Connor, 2017; Starzomski et al., 2023). Within the homecare sector, women primarily administer HCOs in Canada (Gibbon, 1947; Grypma et al., 2012; Hardill, 2006; Saint Elizabeth Health Care [SE Health], 2023). Nursing scholars, such as Klostermann et al. (2022), speak about healthcare and homecare structures as anchored in patriarchal thinking and ways of doing that predetermine rules for nurses and others.

NE positions in HCOs in Canada, such as VON Canada, have their roots in religious and charitable organizations[9] as well as informal caregiving structures of family and community (Gibbon, 1947; Grypma et al., 2012; Hardill, 2006; Stamler et al., 2020). The model of NEs was exported from the United Kingdom to Canada in the nineteenth century, bringing a nursing management style of a trained head nurse who oversaw the female nursing staff (Wildman & Hewison, 2009). Historical accounts show that nurses in these executive positions experienced various challenges (Boyal & Hewison, 2016; Lúanaigh & Hughes, 2016).

NEs in HCOs and other healthcare sectors are members of the senior executive team overseeing the overall provision of nursing and allied health care, personal support care, quality practice, and risk management (American Organization for Nursing Leadership, 2015; Registered Nurses' Association of Ontario [RNAO], 2011). Additionally, NEs are often the executive leads for research and professional development, ensuring that clinical care meets regulatory and legislative standards, managing the clinical informatics portfolio, and representing the healthcare organization at external events and committees (American Organization for Nursing Leadership, 2015; RNAO, 2011). NEs hold undergraduate degrees in nursing; however, there appear to be no requirements for post-graduate nursing and administration education, nor certification in management or leadership (Frederickson & Nickitas, 2011; Laschinger et al.,

[9] Canada has a long history of homecare nursing, beginning with Indigenous women as healers, followed by religious groups such as the Duchess d'Aiguillon sisters and the Grey Nuns in the seventeenth Century (Stamler et al., 2020).

2008). NEs are considered elite by others (e.g., nurses at the point of care, other healthcare professionals, and government decision-makers) in particular discursive situations where they have influence and are represented in certain circles but not in others (Donahue-Ryan, 2020; Fedoruk & Pincombe, 2000; Regan et al., 2016; Robinson-Walker, 2014). Both possibilities coexist within HCOs that are positioned within a neoliberal discursive frame.

Antrobus & Kitson (1999) researched broad socio-political factors impacting NEs in the United Kingdom through a critical ethnographic approach. Semi-structured informal interviews with twenty-four NEs in the United Kingdom revealed that their positions are shaped by the organization's and healthcare system's policy and politics (Antrobus & Kitson, 1999, p. 750). Antrobus & Kitson (1999) also suggested that NEs require knowledge to shape health and social policies in healthcare that impact their daily transactions. The CNA (2009) position statement on nursing leadership indicates that NEs: "must sit at senior decision-making tables and be delegated the authority and resources to implement high-quality care practices." Research has also demonstrated that relationships are critical to successful NEs (Fedoruk & Pincombe, 2000; Frederickson & Nickitas, 2011; Gilmartin, 1996). Roberts's (1997) discussion on the marginalization of NEs illustrates that NEs lack a peer support group, and the need for relationships creates professional isolation.

Professional, political, and social factors such as nursing education and regulation, organizational structures, and healthcare changes have influenced the NE's roles (Adams, 1994; Crawford et al., 2017; Wildman & Hewison, 2009). For example, restructuring healthcare organizations due to reallocating financial resources and shifting priorities often results in eliminating nurses at executive and management levels (CNA, 2009). The precarity of the NE

positions can harm the healthcare organization, impacting nursing staff and management turnover and the safety of people receiving care (Bernard, 2014).

NEs face administrative demands in HCOs that may conflict with their professional values and standards. Aligning nursing values with obligations and constraints in HCOs, which are often driven by profit, is not always possible (Nowak &Bickley, 2005). Bureaucratic knowledge and schematization are developed and used in HCOs to maximize efficiency, optimize resources, and determine healthcare (McGregor, 2001; Rankin & Campbell, 2006; Traynor, 1999, 2017; Woolhandler et al., 2003). Bureaucratic knowledge means the administrative, scientific, and technical knowledge developed by hierarchal states or organizations that highlight administrative activities and policies to guide profit (Felten & von Oertzen, 2020; Graeber, 2006; Valleriani, 2017). Technical rational approaches, where the person, as subject, is always secondary to arrangements of authority in HCOs, can restrict decision-making to one type of knowledge (Salminen-Karlsson & Golay, 2022; Schön, 1983). This focus has been problematized numerous times in the literature, where constant health reforms result in complex work environments with a rigid division of labour (Bruce, 1992; Doran, 2011; Perrow, 2002).

For example, NEs understand the need for RN care in the home of individuals with increased frailty and co-morbidities, but bringing forth this knowledge may be dismissed by non-nurses in executive roles to contain costs within the HCO (O'Connor, 2017). The perceived dominant executive group (i.e., Chief Executive Officer or Chief Financial Officer) may support the organizational discourse by enforcing positional separation of the NE from the nursing workforce and lack of or limited authority compared to the chief of medicine. These may include being the holder of information between the executive group and the nurses at the point of care,

belonging to a social and corporate elite, acceptance by the other executives within the organization, or receiving financial rewards through bonuses (Fedoruk & Pincombe, 2000; Frederickson & Nickitas, 2011). This demonstrates that NEs should align with health organizations' values rather than organizations aligning with nursing values. Other NEs may be disadvantaged through enforced positional separation from the mainstream nursing workforce and lack of or limited authority compared to other HCO executives.

The description of NEs' contribution to health systems is firmly grounded in ideology and terminology consistent with corporate, business, and managerial imperatives. The role of the NE in healthcare organizations is to ensure optimal organizational outcomes through management goals, including efficiency, productivity, and cost-containment, which are not always congruent with nursing values (Baker, 2014; Boston-Fleischhauer, 2016; Nelson-Brantley et al., 2018). NEs are expected to have skills in strategic visioning, organizational decision-making, practice innovation, quality care and client safety, collaboration, and professional accountability (CNA, 2009; RNAO, 2016).

Defining attributes of NEs in the literature have included needing to be persuasive, inspirational, consultative, and political to transmit information to executives and staff at all levels within the organization (Adams, 1994; Buchanan & Badham, 1999; Dwore et al., 1998; Gilmartin, 1996; Kamencik, 2003; Palmer & Dunford, 2008; Scully, 2015). The scholars mentioned above described the consequences of these attributes as significant in making space for nursing practice innovations and ensuring that the innovations were aligned with the changing expectations of people receiving care. They spoke of NEs needing to ensure safety, reliability and cost-effectiveness within the healthcare organizations. When discussing the need to be political, (Fedoruk & Pincombe (2008) and Lúanaigh & Hughes (2016) focused on the

separation of the NE from the nurses at the point of care. Such attributes should confirm NEs' position as full members of organizations' executive teams, but this is not always the case.

NEs are pivotal in healthcare organizations, advocating for health policy and organizational procedures that ensure quality care (Antrobus & Kitson, 1999; Gifford et al., 2014). As mentioned, there is limited research on NEs' value to HCOs. Research has revealed the social, clinical, and economic value of NEs in homecare (i.e., lower medication errors, mortality, and nosocomial infections (Ganann et al., 2019; Jones et al., 2016; Lúanaigh & Hughes, 2016). This has resulted in people receiving better and safer care (Bahadori et al., 2016; Doran, 2011; Huston, 2008; Lúanaigh & Hughes, 2016; Regan et al., 2016; Institute of Medicine (US), 2011; Wong, 2015; Wong et al., 2013). For example, this study was conducted during the Coronavirus (COVID-19) global pandemic[10]. Articles written by NEs from HCOs in peer-reviewed journals exposed the impact of the COVID-19 pandemic on nursing in the homecare sector (Bell et al., 2022; Inloes et al., 2023; Lefebre et al., 2020; Tauseef, 2022). The COVID-19 pandemic is one of the most recent examples where NEs have raised concerns and lobbied organizations and governments to reduce overcrowding and improve clinical care, human resourcing, and public health measures (e.g., SARS, H1N1) (RNAO, 2003; RNAO, 2011, Sharkey et al., 2020). The COVID-19 pandemic has shown the recurrence of organizational and system failures with no changes made.

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[10] In this thesis, the common term used in Canada, COVID-19, will be used when discussing the Coronavirus (COVID-19) global pandemic.

There is an overall understanding that NEs in healthcare organizations benefit outcomes for those receiving care and benefit the organization in terms of the utilization of resources, the identification and prevention of near misses, reducing morbidity and mortality, and the prevention of falls (Lúanaigh & Hughes, 2016; Wong, 2015; Wong et al., 2013). This has resulted in people receiving better and safer care (Bahadori et al., 2016; Doran, 2011; Huston, 2008; Lúanaigh & Hughes, 2016; Regan et al., 2016; Institute of Medicine (US), 2011; Wong, 2015; Wong et al., 2013). While the literature is mainly limited to sectors other than homecare, Lang et al. (2015) noted the importance of investigating safety in homes for people receiving palliative care. Having NEs in healthcare organizations creates space for nursing practice innovation at the point of care, such as implementing models of care that align with the expectations of people receiving care and their families (Adams, 1994; Boston-Fleischhauer, 2016; Fedoruk & Pincombe, 2000; Lúanaigh & Hughes, 2016; Nelson-Brantley et al., 2018).

One point of view expressed in the literature is that NEs are often attributed with promoting the value of nursing, enhancing quality care, upholding nursing professional values and ethics, and attempting to shape the organizational culture that achieves innovations that align with expectations for safe, reliable, and cost-effective service delivery (Boston-Fleischhauer, 2016; Fedoruk & Pincombe, 2000; Frederickson & Nickitas, 2011; Gilmartin, 1996; Johnson, 1989; Lúanaigh & Hughes, 2016; Nelson-Brantley et al., 2018; Randazzo, 2018; Robinson-Walker, 2014). While there are multi-faceted reasons for these, research consistently shows that well-performing HCOs have strong NEs at the executive level (Lúanaigh & Hughes, 2016; Wong, 2015; Wong et al., 2013). However, while recognizing the NE position as important, numerous reports have documented the lack of security, visibility, and formal authority of these

positions across healthcare sectors (Australian College of Nursing White Paper, 2015; Institute of Medicine (US), 2011; Francis, 2013).

2.3 Challenges around NEs – Identity

Identity is formed by social constructs, which are constantly shifting (Albert, 1998; Foucault, 1988). It is defined as a person's commitments, beliefs, and qualities. Some authors have suggested that nursing identity can be built around diverse ways of knowing. It has also been described as built on nursing values such as human dignity, integrity, autonomy, altruism, and social justice (Carper, 1978; Chinn & Kramer, 2017; CNA, 2017). Nurse identity is also seen as technocratic (i.e., task-oriented), embedded in historically inequitable and uncertain positions due to nursing's gendered history (Borman & Biordi, 1992; Rodney, 2013).

NEs' nursing identity is heavily informed during their formal nursing education (Öhlén & Segesten, 1998). NEs establish professional identity as nurses early in their careers within the nursing discipline's social and organizational norms and their management of nursing knowledge (Joseph et al., 2021). NEs' executive identity is further established during professional leadership development and graduate education (Silva et al., 2019). Similarly, the epistemic landscape of organizations, leadership education, and discourses disseminated by nursing associations mould the NEs' executive identity (Alvesson & Willmott, 2002). These discourses all create imagery and the expectation that the NE is influential and authoritative within their hierarchical positioning within HCOs. This has also been influenced by the role of the executive as being predominately constructed by male-gendered identity.

The dual identity of the NE role may be exhibited in a variety of ways, such as advocating for nursing in ways that are deemed to be contrary to the HCO's expectations of the NE role or the nurses at the point of care no longer identifying the NE as a nurse (Ashforth &

Johnson, 2001; Scott, 2011). In both cases, other actors in the organizations. i.e., higher administrators in HCOs or nursing staff, respectively, can make judgments about the positioning of NEs that can leave NEs in an ambiguous and paradoxical position. This uncertain and contradictory position mediates NEs' ability to access organizational knowledge and use their knowledge to exert influence in healthcare organizations.

The NE position is not mandated in HCOs as in hospitals and public health units in Ontario, where NEs have legislated reporting structures and accountabilities (Government of Ontario, 2018; Ontario Ministry of Health and Long-Term Care, 2003). There does not appear to be any literature indicating why the NE position in HCOs is not mandated. However, I suggest it is not mandated as the homecare sector is not part of the *Canada Health Act*.

Nursing leadership in Canada has historically been concerned with skill-based and relational approaches. The description of NEs' contribution to health systems is firmly grounded in ideology and terminology consistent with corporate, business, and organizational goals (Fedoruk & Pincombe, 2000; Lúanaigh & Hughes, 2016). Traditional ways of speaking about NEs lead to discourses that emphasize individual competencies, attributes, behaviours, and skills. Scholars continue offering solutions focusing on individual competencies and behaviours, organizational policies, and legislation (Chreim et al., 2013, 2020; Croft et al., 2015; Scott, 2011; Thompson & McNamara, 2022). The literature on nursing leadership and management centers on a suggested heroic individual narrative, whereby the individual NE is responsible for the outcomes of nursing care (Bahadori et al., 2016; Hannah et al., 2014). This type of heroic individual narrative leads to predefined characteristics of self-sacrifice and a meaningful understanding of the NE role. When such goals are unmet, other executives turn to the individual NE to understand what happened.

2.4 Rethinking current conceptualizations of NEs through a critical lens

What can be extrapolated from the previous sections about NEs is that a strong nursing presence is needed in HCOs. This gap is evident in the literature. Defining NEs by their roles, responsibilities, and attributes limits the understanding of NEs' subjectivity, which is influenced by the context, structures, and discourses within the HCOs in which they function. This justifies exploring NEs in HCOs through identity and agency rather than roles, responsibilities, and attributes.

NEs express agency, which is "discursively produced in their social interactions" in everything they do (Weedon, 1997, p. 176). In so doing, they bring forth ideas, recommendations and decisions that other senior executives often perceive as serving the nursing profession rather than the HCO (Batcheller, 2010; Perron et al., 2020). Agency, for this study, "refers to the thinking subject possessive of intentional actions" (Alvesson et al., 2009, p. 169). NEs enact agency based on what they know, do not know, or do not want to know. The agency of NEs within their context is central to this study. NEs make choices daily about the (perceived) right course of action based on evaluating particular situations. Their ability to manage decisions is also said to be based on their ability to act like a nurse and executive. As described by NEs, this notion of professionalism is heavily bound by and couched in the discourses put forth by nursing education, professional development, nursing organizations, and regulatory bodies (College of Nurses of Ontario, 2023; RNAO, 2007).

2.4.1 Nurse Executive Moral Agency

Morality is necessary "as part of the ontological basis for leadership" (Hannah et al., 2014, p. 604). Moral agency for nurses is defined as carrying out a person's motivation and physical actions to an ethical conclusion (CNA, 2017; Yarling & McElmurry, 1986). From an

agentic perspective, the NE should define this. However, an NE's ethical conclusion can also be reached by the nursing regulatory body that publishes and enforces the code of ethics in Ontario (College of Nurses of Ontario, 2023a). This supports the idea that NEs may experience tensions due to misalignment between their moral agency and that of the expectations of the HCO. Like NEs in other healthcare settings, NEs may not be free to be moral agents in HCOs but are restricted by the need to address multiple institutional demands (Austin, 2011; Douglas, 1986). Corporate imperatives in HCOs drive a financially motivated service model that often sacrifices a culture of care (McMillan & Perron, 2020a), fundamentally shaping nurses' moral commitments. These requirements influence the provision of care for those people requiring services from the HCO.

NEs are often expected to be aligned with HCOs' values while upholding their values and those of the profession (Batcheller, 2010; Gilmartin, 1996; RNAO, 2011; RNAO, 2016). I have not identified any literature that speaks about the tensions between NEs' moral agency and the expectations of healthcare institutions. The wording of documents about nursing leadership suggests that nurses can uphold such values fairly unproblematically (CNA, 2009; RNAO, 2016), regardless of the setting.

Nurses often engage in deliberate actions with moral overtones demonstrated in their daily relationships, transactions, and negotiations (Liaschenko & Peter, 2016; Starzomski et al., 2023). They are expected to uphold their values and those of the profession (Batcheller, 2010; Gilmartin, 1996; RNAO, 2011). For NEs, their moral agency is impacted by what they know and do not know (Rodney, 2013; Starzomski et al., 2023). Similar to nurses in other positions, NEs may not be free to be moral agents in HCOs, but rather are restricted to addressing multiple institutional and often competing demands (Douglas, 1986).

2.4.2 Nurse Executive Political Agency

Researchers do not explicitly define political agency and socio-professional agency. However, for my proposed research, I am describing political agency as one's ability to exert political action (i.e. advocating for increased numbers of RNs at the point of care or increased hours of service for people who are frail) to influence strategic decisions and promote social change (Antrobus & Kitson, 1999; Boyal & Hewison, 2016; Lúanaigh & Hughes, 2016; Perron et al., 2005).

For this research, political agency also refers to the capacity to participate in power-laden spaces, activate levers of influence, and attempt to shift how society is organized (McMillan & Perron, 2020a). For an NE in an HCO, this may be exemplified by bringing forth arguments specific to the audience with which the NE is engaged in the HCO.

NEs' political agency is enacted when they engage within power structures to enact influence to promote social change (McMillan & Perron, 2020b). In scholarship, understanding political agency is often limited to exerting leadership influence based on certain skills.

NEs' political agency involves knowledge and ignorance (Townley, 2006). This is discussed more in Chapter 3. Faced with restricted opportunities to influence organizational direction and performance, some NEs decide to move on to a different position elsewhere or leave nursing positions entirely and choose different careers (Daley, 2013; Lúanaigh & Hughes, 2016; Nowak & Bickley, 2005), further compounding the organization's loss of both nursing and leadership experience, expertise, talent, and capacity.

2.4.3 Nurse Executive Socio-professional Agency

Socio-professional agency is not a term defined in the literature. The term "socio-professional" is used by sociologists of ignorance to refer to individuals' social belonging and

professional life. Socio-professional agency encompasses economic activity, status, qualifications, and hierarchal positions for this study. Therefore, the definition for this research is that socio-professional agency is the ability to act in spaces designed by and for professionals who belong to a regulated profession. NEs derive a certain status from that which shapes the type of agency that they embody in those spaces. Socio-professional agency is defined as a nurse's professionalism and connection with historical constructs and social processes.

For an NE in an HCO, this may be exemplified as advocating for changes in service delivery models, which are supported by research, which increase the number of RNs at the point of care or increase the hours of service for people who are frail. These political actions influence strategic decisions and promote social change (Antrobus & Kitson, 1999; Boyal & Hewison, 2016; Lúanaigh & Hughes, 2016; Perron et al., 2005). Political agency is demonstrated by bringing forth arguments that are specific to the audience that the NE is engaged within the HCO (i.e., to the CEO or President) and context-dependent (i.e., how the argument aligns with HCO imperatives or not) (Balzaq, 2005; McMillan & Perron, 2020b).

Hierarchical relationships and understanding of NEs, or not, are embedded within HCO organizational cultures. Examining the impact of HCOs as epistemic spaces and their impact on NEs agency is required. Organizational arrangements of authority may conflict with NEs' knowledge of the needs of people requiring care because of the tension and juggling of two ideologies that shape their identity as both a nurse and an executive (Ganz et al., 2015; Kortje, 2016; Prestia et al., 2017). NEs in HCOs comprise a very neglected area of research. This justifies this inquiry to focus on the social, epistemic, political, and moral structures within HCOs that can impact the NE. This perspective allows for a radical rethinking of NEs as epistemic agents and HCOs as epistemic spaces. What the institution professes as valued may

differ from what is enacted in practice. This value restriction hinders the NEs' epistemic agency (Foucault, 1980; Graeber, 2012; Raffnsøe et al., 2017; Mills, 2003). Consequently, it matters when considering NEs as epistemic agents and HCOs as epistemic spaces. Therefore, I chose to use a framework that combines CMS, as informed by Foucault, and the SoI, which will be developed in the following chapter.

Chapter 3: Theoretical Considerations

As noted in the preface, this chapter is an original manuscript published in *Nursing Philosophy*, where I am the first author. Ashley, L., & Perron, A. (2023). Examining the role of nurse executives in homecare through the lens of the Sociology of Ignorance and Critical Management Studies. *Nursing Philosophy*, e12445. https://doi.org/10.1111/nup.12445

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This article presents a theoretical approach of CMS, as informed by Foucault, and the SoI. This article describes NEs and HCOs in Canada and deliberates the concepts of epistemic agency, ignorance, knowledge and power.

3.1 Examining the Role of Nurse Executives in Homecare Through the Lens of the Sociology of Ignorance and Critical Management Studies

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3.1.1 Abstract

This article presents a novel theoretical approach to explore nurse executives' paradoxical identity and agency of executive and nurse in homecare organizations. This complex phenomenon has yet to be well theorized or analyzed. Through a synthesis of literature, we demonstrate that Critical Management Studies, as informed by Foucault, and the Sociology of Ignorance, can create a different understanding of the complex interplay between knowledge and nonknowledge (ignorance) that positions nurse executives in both influential and precarious ways in homecare organizations. This theoretical framework has the potential to allow for the explicit exploration of nurse executives' strategic epistemic and discursive positioning and highlights hierarchal power structures within homecare organizations. We posit that this framework, that spans nursing, management and sociology disciplines, sets a different understanding of homecare organizations as epistemic landscapes, exposing institutional

knowledge and ignorance dynamics that remain largely concealed and unchallenged, yet are integral to understanding nurse executives' epistemic agency.

Keywords: Critical Management Studies, homecare, ignorance, knowledge, nurse executive, Sociology of Ignorance

3.1.2 Introduction

Nurse executives (NEs) experience paradoxical identities and agency of executive and nurse in homecare organizations (HCOs). Tensions arise from living with two sets of values and knowledge (e.g., nursing and management) and conflicting organizational roles. This dual positioning, with values, expertise and agency grounded in identities of both executive and nurse, illustrates the complexity of the NE role. This phenomenon has yet to be well theorized or analyzed.

To better understand this complex duality, we present a theoretical framework of Critical Management Studies (CMS), as informed by Foucault, and the Sociology of Ignorance (SoI). Through a literature synthesis, we demonstrate that CMS and the SoI can work together to help understand NEs' complex experiences in HCOs. This theoretical framework, currently being used in the first author's research, has the potential to allow for the explicit exploration of NEs' strategic epistemic and discursive positioning and highlights hierarchal power structures within HCOs. We posit that this framework will also make a unique theoretical contribution, as CMS and the SoI are not well known in the discipline of nursing and have never been used together in research.

In this article, we explore how overt and covert power, knowledge and ignorance dynamics within HCOs mediate organizational enactment of NE positions. These socially, historically and politically entrenched dynamics in the healthcare system can shift the

understanding of NEs as epistemic agents (Douglas, 1986; Perron & Rudge, 2016). Similarly, these dynamics can shift the understanding of HCOs as epistemic landscapes, institutions where knowledge is developed over time based on history, politics and social circum- stances, determining the division of labour within the HCO (Weisberg & Muldoon, 2009).

We introduce this framework by first setting the context of NEs' agency as heavily grounded by the discursive and epistemic practices of the HCOs in which NEs enact their role. That is, we can understand NEs as strategic agents in how certain knowledge and discourses are deemed legitimate and dominant in HCOs and others less so. We then propose how CMS and the SoI can work together to explore the discursive, epistemic and power transactions occurring in the upper management of HCOs through NEs' strategic organizational positioning.

3.1.3 Delineations of NEs and HCOs In Canada

NEs are the highest level administrative registered nurse in HCOs, responsible for overseeing administrative (e.g., operational budgets) and clinical nursing functions (e.g., nursing personnel, technological innovations and new models of care). These functions require knowledge and expertise in nursing, management, leadership, planning, policy, communication, budgeting and organizational change (Antrobus & Kitson, 1999; Frederickson & Nickitas, 2011; Walls, 2012). Our use of the “Nurse Executive” (NE) designation aims to encapsulate the various terms and titles used to describe nurses in such roles, such as Chief Executive Nurse, Chief Nursing Officer, Vice President, Senior Nurse Officer, Senior Nurse Leader, Nurse Administrator, Senior Nurse and Director of Nursing (Batcheller, 2010; Frederickson & Nickitas, 2011; Titzer & Shirey, 2013). Although the NE position is viewed internationally as essential (Australian College of Nursing [ACN], 2015; Institute of Medicine, 2011; Martin, 2013), it is not always mandated in Canada in the homecare sector.

A neoliberal discursive frame that quantifies nursing services through standardization, benchmarking and reduced cost centres of services impacts NEs working in HCOs (O'Connor, 2017). Specifically in Canada, homecare is considered an extended service to the *Canada Health Act* (Romanow, 2002), wherein through contractual arrangements, for-profit and nonprofit organizations receive limited funding from the government. Moreover, other HCOs do not receive any funding from the government. In either model, patients may receive care that only meets some of their needs and ability to pay. Social and political issues throughout history, such as technological advances, women's entry into the workforce and the historical subordination of nursing to medicine, have influenced NEs' positionality in healthcare (Egenes, 2017; May & Fleming, 1997). These social and political developments have varyingly shaped NEs' identity and influenced how others view and value them, such as healthcare executives and professionals, patients and the government.

NEs in healthcare hold conflicting statuses concerning power, authority, credibility and legitimacy. They often experience contradictions about how powerful their voice can be and how much influence they can exert (Jones et al., 2008; Kelly et al., 2016; Lúanaigh & Hughes, 2016). NEs experience conflict between being able to address operational workforce issues and making ethical nursing decisions (Kortje, 2016). Difficulties that arise from such conflict are often explained by identifying gaps in NEs' skill sets. These gaps are often justified as the NE requiring more leadership, management, corporate communication or financial education (American Organization for Nursing Leadership [AONL], 2015; Donohue-Ryan, 2020; Registered Nurses' Association of Ontario [RNAO], 2011). Education, skills, competencies and knowledge have long been deemed essential for NEs to lead effectively. Any gap is assumed to be identifiable and fixable through acquiring additional, focused knowledge.

Current organizational and nursing leadership approaches suggest that NEs can enact leadership, influence and agency by acquiring and enacting new knowledge. These approaches focus on improving NEs' leadership competencies and knowledge to improve their ability to function (Cummings et al., 2021). This individualized focus is often prioritized without consideration for the power and knowledge dynamics underpinning the popular notions of collaboration, communication, influence and respect (Hurley & Linsley, 2007). We argue that equal attention must be paid to how NEs can be made not to know something or be de-legitimized knowers through routine organizational activities, discourses and priorities.

Understanding the flow of knowledge (or lack thereof) in HCOs is one approach needed to unpack the epistemic agency of NEs. Such an analysis requires a robust framework to conceptualize power, knowledge and ignorance (as a form of nonknowledge) in organizations. We propose a framework that combines CMS and the SoI to provide a new understanding of the issue, thus leading to different solutions.

3.1.4 CMS

CMS is a “pluralistic, multidisciplinary movement” that draws from Weber and Marx and the Frankfurt School of Critical Theory (Alvesson et al., 2009; p. 43). CMS is grounded in the notion that management, businesses and organizations are capitalist, and the individuals within them are shaped by society (Alvesson et al., 2009; Grey & Willmott, 2005). Various theories, such as poststructuralism, pragmatism and critical realism, have influenced CMS. Authors such as Foucault and Habermas have had several influences on CMS, leading to different analytical frameworks. We are specifically interested in CMS as informed by Foucault's (1980, 1982) conceptualization of power as productive and inseparable from knowledge. In this view, CMS is concerned with the role of dominant discourses and practices in organizations and how they

foster specific ways of thinking, speaking and doing. It helps to expose “the multiple locations of power” and the “multiple interconnections between relations of power and knowledge” (Barratt, 2004, p.193). CMS is a fully theorized critical perspective used in nursing research by only a few scholars (Dahlke & Stahlke Wall, 2017; McMillan & Perron, 2018).

CMS questions the authority, relevance, legitimacy and efficacy of mainstream thinking and assumptions about organizational ideologies and hierarchies. We use CMS to look at the prevailing relations of power that underpin them and the existing tensions between executives in an organization (Alvesson & Deetz, 2000; Grey & Willmott, 2005). It is concerned with the identity of organizations and the individuals within them and provides a theoretical understanding of the complex articulation of identity, agency, power and knowledge. Alvesson et al. (2009) view identity as self-constructed through social interactions and power operations. CMS scholars posit that organizations display many power relationships that are not always linear and that all individuals in organizations have power and use their power to enact agency (Alvesson et al., 2009). However, the strength and impact of their power may be where some actors have pervasive power, whereas others have subtle power (Bergstorm & Knights, 2006). Whether or not the exertion of power is reflected in the larger organizational narrative is determined by institutional practices and social, cultural and political structures created and maintained (King & Learmonth, 2015; Wickert & Schaefer, 2015). CMS can offer insight into how NEs shape their identity, use power and knowledge, and how others' power and knowledge shape them. Building on the assumption that leadership styles are rooted within socioeconomic and political processes, CMS lets researchers expose and challenge what is taken for granted and established (Alvesson et al., 2009).

Three core elements of CMS can be used to examine what is occurring in HCOs that influence the NE's subjective positions (Fournier & Grey, 2000). The first element, *de-naturalization*, looks at what is legitimized. For example, hierarchy is expected in an HCO, and the NE may be presumed to focus on clinical care. The second element, *anti-performativity*, focuses on whether knowledge has value in an organization and what social relations are dominant. It can be used to look at the ethical and political organizational culture of an HCO and how it aligns with those of the NE and nursing more broadly. Finally, *reflexivity* fosters critical self-reflection to identify all explanations of organization and management.

The notion of knowledge becomes a central piece of this article. CMS argues that organizations are viewed as social machines that produce discourses and knowledge. People's thoughts, speech and actions are heavily governed by those discourses, drawing on what they know and consciously or unconsciously do not know. By examining how people and institutions wield power, how power operates and how it controls and produces new behaviours, individuals and institutions can be seen as active players in its performance, where discourse permits and limits knowledge production (Alvesson et al., 2009). As informed by Foucault, CMS helps reveal the rules that regulate and govern social practices that may be known and unknown to organizational actors. It can help uncover how organizational actors navigate the organizational spaces (social, discursive and ideological) in their work by critically addressing notions of power, knowledge, discourses and organizations.

We recognize that some forms of knowledge are valued or accessible while others are not. One limitation of CMS is that it does not delve into ignorance as an act of power but instead points to a lack of knowledge (Alvesson & Spicer, 2012). Nor does it consider that epistemic

discourses within organizations can result from the workings of ignorance. We explore this further with the SoI.

3.1.5 SoI

The SoI is a theoretical position heavily grounded in feminist scholarship, political science, philosophy and sociology (McGoey, 2007, 2012a; Perron & Rudge, 2016). It considers that ignorance can be harnessed as a resource, enabling knowledge to be deflected, obscured, concealed or magnified to increase the scope of what remains unintelligible. In this view, ignorance is as important as knowledge when understanding the flow of discourses and perceptions and the routine ways we obtain, sift through, interpret, understand and remember certain information and data, or the lack thereof, and when that is considered inconsequential or problematic. This notion challenges the conventional understanding of ignorance as to the absence or distortion of knowledge in society (McGoey, 2012b; Perron & Rudge, 2016).

Similar to CMS, the SoI is partially influenced by Foucault (1980). Foucault (1980) described disqualified knowledge as knowledge with a historical value that should be known and understood but deemed unnecessary, irrelevant or inadequate. He described disqualified knowledge as valid for some individuals and not others, leading to the devaluation of certain discourses in favour of others (Foucault, 1980). Knowledge is inextricably linked to power, whether dominant or disqualified.

The study of ignorance has historical foundations in ancient Greece through Socrates, who spoke about ignorance as part of one's wisdom (Harvey et al., 2001). It is historically, spatially and temporally bound (Perron & Rudge, 2016). It can be considered an organizational living entity with its own practices, discourses and experiences of what is not known, cannot be known, or refused to be known through the production of everyday activities (Harvey et al.,

2001; Proctor & Schiebinger, 2008). Ignorance works similarly to knowledge but as a form of nonknowledge, influencing how organizational agents manage daily administrative, discursive and clinical processes. When studying the context of discourses and arrangements in HCOs, the SoI brings forth a richer understanding of ignorance as something productive, political, and in some cases, positive (Perron & Rudge, 2016).

If we consider that HCOs have epistemic authority where “knowledge and ignorance continually intersect” (Perron et al., 2020, p. 117), then specific knowledge may be available to some executives and not to others, maintaining the organization's bureaucratic authority (Bakonyi, 2018; McGoey, 2007). This is where the SoI provides insight into how ignorance plays out in social contexts such as HCOs.

The SoI can bring to light blind spots in individual and organizational knowledge created through wilful or accidental over- sight, uncertainty, omission, neglect, forgetfulness, censorship or dismissal. Considering what knowledge becomes visible, becomes missing, and what might be construed as a personal or an organizational blind spot may determine who is a credible knower in HCOs (Reider, 2016). The SoI is a valuable complement to CMS' theoretical understanding of power and knowledge. It offers significant insight into how NEs shape their identity by using power and knowledge and how they are shaped by others' use of power and knowledge.

3.1.6 Integration of two theoretical perspectives

CMS and the SoI are philosophically congruent theoretical perspectives. Concepts of power, knowledge, discourse, identity and subjectivity are central in both, albeit in differing ways. We posit that CMS and the SoI can create a different understanding of the interplay between knowledge and nonknowledge (ignorance) that positions NEs in influential and precarious ways in HCOs. For example, CMS's theoretical understanding of identity, agency,

power and knowledge offers significant insight into how power, knowledge and discourses shape NEs' subjective experiences in organizations such as HCOs. CMS challenges the idea that hierarchical power relations tend to flow downward from the executive level.

Incorporating the SoI into the framework prompts an examination of how ignorance influences organizational dynamics. Organizational dynamics such as power relationships, just as much as (and sometimes more than) knowledge. Using the SoI allows us to examine the knowledge/ignorance dynamics that run across HCOs, including in upper levels of management and within NEs' relationships with other executives, navigating various occurrences of individual and organizational ignorance. Adding the SoI also allows for exploring how ignorance is strategically managed within HCOs. Therefore, it complements CMS by building upon Foucault's notion of disqualified knowledge. It also provides further insight into how ignorance circulates and operates and when ignorance is used as a means to an end.

We suggest that CMS can serve to explain how organizational work in HCOs is accomplished by permitting certain ways of thinking and excluding others. For example, principles of functioning, patterns of authority and hierarchical structures in HCOs are well established, creating a distinct division of epistemic labour (Douglas, 1986). HCOs may limit or strengthen NEs' contribution to the organization, influencing what knowledge is produced and valued and how it is organized. This depends partly on a NE's ability to access information and executive team members (e.g., the Chief Executive Officer). HCOs may also function according to policies, procedures and governance structures that do not critically reflect nursing services or their organizational or social value. As one of many organizational agents, NEs have to navigate, think strategically, and mediate the flow of knowledge within an HCO. NEs manage daily transactions and negotiations, face resistance and enact agency based on what they know, do not

know, may not want to know, and may not want others to know. CMS helps us to focus not only on NEs as individuals in an organization but also on HCOs as multifaceted social structures that organize patients, healthcare professionals and administrators (i.e., NEs) in distinct ways.

Power and discursive structures within HCOs impact whether NEs have power, advantages and opportunities, which may result in contradictory positions for NEs. Such structures should confirm NEs' position as full members of the organization's executive teams, but this is not always the case. For instance, NEs may be left out of certain processes or decisions and may have their nursing knowledge dismissed (i.e., ignored) by other executives. Significant tensions regarding NE's organizational positionality emerge where knowledge and ignorance intervene.

Dominant knowledge within the HCO creates specific kinds of understandings and expectations about legitimate nursing leadership. Falling outside these makes other forms of nursing leadership (e.g., clinical leadership) illegitimate because they are unrecognizable in organizational discourse. Therefore, the prevailing discursive and epistemic arrangements in HCOs create and maintain particular pockets of organizational ignorance in which NEs participate (McGoey, 2007; Townley, 2011). Organizational ignorance is produced and maintained (accidentally or wilfully) by a range of events, such as suppression, unquestioned traditions, selective cultural or political inquiry, loss of institutional memory, inattention or deliberate or unintentional neglect (Bakonyi, 2018; McGoey, 2012a, 2012b; Proctor & Schiebinger, 2008; Townley, 2011). Epistemic arrangements in HCOs, therefore, shape the discursive practices, subjectivity and the positionality of NEs. This is done through the daily management of knowledge flows and interruptions.

NEs in HCOs are positioned as holding (or not) relevant expertise and knowledge that predetermines interactions where their status and influence hinge on the access to and strategic management of competing forms of knowledge (Perron & Rudge, 2016). Issues around power, discourse and knowledge intersect, with NEs as just one part of that network. This paradoxical position mediates NEs' ability to access organizational knowledge and use such knowledge to exert influence on HCOs and, to some extent, the broader healthcare system. In that sense, the SoI complements a CMS perspective well: in CMS, the notion of nonknowledge and its ability to both interrupt and amplify the flow of power (McGoey, 2007; Perron & Rudge, 2016) is not given adequate attention. The SoI allows one to examine which discursive practices legitimize certain kinds of knowledge and which aspects of these organizations benefit from interrupted flows of knowledge (i.e., ignorance) (Perron et al., 2020).

Strategic filtering of information based on perceived legitimacy (or lack thereof) enhances or suppresses certain forms of knowledge in HCOs. Not all forms of knowledge are valued equally, thereby creating epistemic hierarchies. Certain kinds of knowledge are seen as legitimate and influential (e.g., empirical, technocratic and statistical), and others less so (personal, ethical and observational) (Chinn & Kramer, 2017). Therefore, certain forms of nursing knowledge may be disqualified in HCOs (McMillan & Perron, 2020a). By using CMS, we can pay attention to knowledge and how knowledge affects NEs' ability to perform their functions. In addition, the SoI lets us explore ignorance, how NEs can become enrolled in the workings of ignorance, and how NEs actively mobilize ignorance to pursue particular aims. For example, NEs may sometimes compromise and resist rules and norms in HCOs to manage expectations and meet their agenda.

These theoretical perspectives can help one understand how ignorance is managed strategically within HCOs. The SoI can inform the unspoken experience of NEs. It highlights knowledge tensions and patterns within HCOs and how ignorance is utilized to meet agendas and bring forth certain narratives. It can explore how NEs influence knowledge and ignorance patterns and use them to achieve specific outcomes.

NEs' epistemic agency emerges from their engagement with and mobilization of ignorance with themselves and others, as it does from their engagement with knowledge (Perron & Rudge, 2016; Reider, 2016). We posit that CMS and the SoI help us explain how knowledge is legitimized or neutralized and how power is distributed and valued across HCOs. For this reason, it is essential to understand how NEs' motivations, priorities and actions rest on knowledge and ignorance arrangements—that is, to understand NEs as epistemic agents. We argue that, as epistemic agents, NEs are in an ambiguous situation and embody authority due to their hierarchical position and status. However, they are also embedded in social, cultural and professional processes that carry historical and gendered inequities impacting the profession's status and influence (Fedoruk & Pincombe, 2000; McMillan & Perron, 2020b).

CMS and the SoI work together to explore how NEs become a site of application of power dynamics, discourses, norms and expectations, upholding the epistemic arrangements within HCOs by actively deploying their decisions, motivations and priorities toward the goals of the HCO. By manifesting the HCO's norms, expectations, language and cultural codes, NEs manipulate the structures to meet and, likely reconcile, various agendas. They do this by using their reasoning, resources and problem-solving to promote and enforce nursing practice and competencies within the pre-existing epistemic landscape of the HCO. Although NEs are seen as pivotal assets to the HCOs' corporate objective, the value of nurses, nurses' knowledge, or the

multiple forms of nurses' leadership are instrumentalized. NEs work to secure a space for nursing where they are not just instrumentalized but can be legitimized. Using CMS and the SoI creates the potential to analyze prevailing discourses that would enable nurses and nursing care, expertise and leadership to be valued only in specific and restricted ways to meet corporate objectives.

3.1.7 Conclusion

Nursing research and theory have not examined the contrived imbalance of knowledge and nonknowledge (ignorance) that maintains the current power arrangement in HCOs, which impacts NE's enactment of their role. Although nursing and sociological analyses have examined nurses at the bedside and in middle management positions, and the interprofessional dynamics between healthcare professionals, limited research has explored the discursive, epistemic and power transactions occurring in healthcare organizations through NEs' strategic organizational positioning. As such, we have proposed a novel theoretical approach to explore NEs' paradoxical identities and agency of executive and nurse in HCOs.

Understanding the flow of knowledge (or lack thereof) in HCOs is one approach needed to examine the epistemic agency of NEs. The theoretical perspective combines CMS and the SoI to provide a new understanding of the issue, thus leading to different solutions. CMS and the SoI can collectively demonstrate how varying knowledge tensions and ignorance commitments are used in HCOs to bring forth certain narratives and the tensions between those narratives. CMS and the SoI work together to create a useful framework for unpacking the interplay between knowledge and ignorance that positions NEs in HCOs. CMS and the SoI can be used to examine and reveal the epistemic and discursive positioning of NEs' at the individual, organizational and systemic levels, highlighting the power structures in these organizations.

We have proposed a unique theoretical contribution that can support the further development of nursing knowledge, with particular attention to the distinctive epistemic agency of NEs. The notion of epistemic agency provides new knowledge of traditional nursing leadership literature. The need for new critical theoretical perspectives that combine nursing disciplinary knowledge with a sociological viewpoint can enhance nursing disciplinary knowledge by better understanding the various knowledge and nonknowledge (ignorance) relationships within which NEs are embedded. We raise concerns over understanding what knowledge is legitimized and taken for granted by broadening the conceptual and theoretical thinking of NEs as epistemic agents. We propose that how NEs shape their identity by using power, knowledge and ignorance and how others shape their use of power, knowledge and ignorance has value. CMS and the SoI set a different understanding of HCOs as epistemic landscapes, exposing institutional knowledge and ignorance dynamics that remain largely concealed and unchallenged yet are integral to understanding NEs' epistemic agency.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

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3.1.8 References

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Chapter 4: Methodology

This chapter describes the methodology for my critical study of nurse agency in HCOs. The first section discusses CDA, focusing on why I chose CDA and, more specifically, Fairclough's (2013) CDA framework for this research. An overview of Fairclough's methodology is provided, as well as an explanation of how it relates to this study. The second section discusses the procedures for data collection, including tools and recruitment methods. The third section focuses on Fairclough's three levels of discourse analysis to identify dialectical relations, including textual, process, and social analyses. The chapter concludes by addressing methodological trustworthiness, reflexivity, and ethical considerations.

4.1 Critical Discourse Analysis

CDA has interdisciplinary roots in Linguistics, Anthropology, Philosophy, Sociopsychology, and Cognitive Science (Wodak & Meyer, 2016). The leading scholars of CDA include Fairclough, Wodak, van Leeuwen, and van Dijk (Wodak & Meyer, 2016). Evolving from the 1970s, CDA is an interpretive and explanatory approach used to analyze text and social order function and action (Wodak, 2002; Wodak & Meyer, 2016). It is used to understand society and study power relations and ideologies by investigating written, spoken, or visual texts and analyzing discourse (Wodak & Meyer, 2016). However, while this methodology has been used to examine areas such as forensic psychiatric nursing, patient interactions, and professionalism in nursing, it has not been used to examine NEs or HCOs (Dahlborg et al., 2023; Domingue et al., 2023; Jager & Perron, 2020; Lupton, 2013; Smith, 2007). Feminist scholars have used CDA to explore gender and power (Cheek, 2004; Lazar, 2005; Miller, 2000).

Critical social theorists, including Foucault, Bourdieu, and Habermas, have shaped how power and discourse are conceptualized in CDA (Bourdieu et al., 1996; Foucault,1984; Foucault,

1980;). Within CDA, discourse is seen as an ideological flow of knowledge and a form of social action (Fairclough & Wodak, 1997). For example, NEs act, react and attach meaning to their actions and those of others. The analysis of organizations, seen as unique discursive objects, includes examining the discourse within organizations and the relationship between discourses and the actions of individual agents (Chouliaraki & Fairclough, 2010).

The use of CDA as the methodology for my research aligns with my epistemological stance of critical theory and my concepts of interest, including power and agency. While different CDA approaches examine discourse and society, the use of Fairclough's (2001) analysis of the "dialectical relationships between semiosis and other elements of social practices" (p.123) differentiates it from other CDA approaches. Fairclough's (2013) approach to CDA includes the flexibility of using multiple entry points for a comprehensive analysis. I use Fairclough's CDA approach to examine homecare NEs' discourses, understand what is revealed about circulating knowledge and ignorance in HCOs, and how NEs enact agency in that context.

4.1.1 Fairclough's CDA approach

As mentioned above, Fairclough (2013) is one scholar of CDA. His approach is based on the theoretical work of Foucault, Marx, and Halliday. In this study, I have used Fairclough's (2013) CDA framework, based on Foucault (1980), to understand NEs as moral, socio-professional, political, and epistemic agents in the complex epistemic landscapes of HCOs.

This approach examines structures and events within social processes, including language and text, and discourse within power relations within an interdisciplinary framework (Fairclough, 2013). Fairclough (2013) sees dialectical relations as social relations that may be different but not exclusive. He views discourse as historical, ideological, and social action comprising society and culture. He describes discourse as "semiotic ways of construing aspects

of the world (physical, social, or mental) which can generally be identified with different positions or perspectives of different groups of social actors" (Fairclough, 2013, p. 232).

This sociological application of discourse analysis examines dialectical relations, identifying the ideologies that mediate between language and society (Fairclough, 2001; Wodak & Meyer, 2016). Fairclough's approach to CDA studies discourse practices within broader social and cultural dimensions, examining how events have occurred, what has shaped them ideologically, what is apparent, and what may be hidden (Fairclough, 2013).

Fairclough's methodology reveals the social context and discursive practices surrounding social wrongs. This is where Fairclough (2013) introduces his concept of interdiscursivity into his CDA approach. He aligns this concept with Foucault's work on power in modern societies as embedded in social institutions and Foucault's interpretation of discourse as being historically mediated. Fairclough's attention to social and political matters relating to power and dominance aligns with Foucault's theoretical underpinnings and his conceptualization of knowledge and power (Fairclough, 2013; Foucault, 1982).

Fairclough's understanding of dialectical relations is drawn from Foucault's interpretation of relations (Fairclough, 2013). While Foucault (1982) does not use the term dialectical, he speaks of how relations with oneself, one's actions, and control over things are interrelated. Fairclough (2013) sees the complex relations that Foucault (1980) addresses as dialectically related and not discrete. Relations influence discourses, knowledge, and power that semiotics can analyze. Following Foucault, Fairclough understands discursive practices as producing and reproducing power. Both of their conceptual understandings are important to this research. For example, in his work, Fairclough (2013) focused on analyzing capitalist societies, looking at the relationships between neoliberalism and societal structures, such as healthcare, politics, and

education. By examining the influence of neoliberalism on society, he proposes that neoliberalism's effect on power relations, injustices, and inequalities can be identified through observing social wrongs, and obstacles may be overcome or mitigated. This is relevant to my study as HCOs function within a neoliberal discursive frame, creating discourses and knowledge–power relations that position NEs in particular ways.

Fairclough positions his dialectical-relational approach to CDA within a four-stage methodology, which includes a three-dimensional framework for analysis (Fairclough, 2013). While this appears complex, researchers can position their research within a transdisciplinary theoretical framework. Fairclough (2013) does not impose that researchers from different disciplines lead transdisciplinary research. Instead, he describes it as building a theoretical framework that focuses on "insights or problems captured in other theories and disciplines from the perspective of one's particular concerns" (Fairclough, 2013, p. 295). This three-dimensional framework for analysis is further described in my section on Data Analysis.

4.1.2 Fairclough's Four Methodological Stages

Fairclough's CDA methodology involves a set of four stages that include:

Stage 1: Focus on a social wrong in its semiotic aspect.

Stage 2: Identify obstacles to addressing the social wrong.

Stage 3: Consider whether the social order 'needs' the social wrong.

Stage 4: Identify possible ways past the obstacle. (Fairclough, 2013).

According to Fairclough (2013), *Stage 1*: *Focus upon a social wrong, in its semiotic aspect*, involves finding a research topic and setting the theoretical framework within a transdisciplinary context. As discussed in earlier chapters, my study theoretically spans the disciplines of nursing, sociology and management. A topic of research involves identifying what Fairclough describes

as a "social wrong," which "include(s) injustices and inequalities which people experience" that relates to a problem in society that is researchable and that requires some resolution (Fairclough, 2013, p.226). He suggests that social wrongs can be identified, and knowledge can be produced to contribute to social change. The researcher can identify and examine these social wrongs through their discourses and semiotic structures. Fairclough (2013) defines semiotics as language and visual images that are part of social structures. He speaks about events as complex and contradictory.

For this study, NEs hold conflicting statuses in HCOs and experience tensions between their identity as nurses and executives. I am focusing on this as a social issue, using my research questions to guide my study. The construction of work environments that foster this identity tension is a social issue if we consider that NEs' agency is mediated by power, knowledge, and socially entrenched ignorance dynamics within HCOs.

Fairclough's (2013) *Stage 2: Identify obstacles to addressing the social wrong* involves considering ways to deal with the social wrong. The object of research is analyzed through the language used and social practices. Social structures are examined that are preventing the social wrong from being addressed. This is done by analyzing language by looking for metaphors and ideologies within their social context (Fairclough, 2013; Wodak & Meyer, 2016). This level connects what is being spoken or written with social practices. Texts relevant to the social wrong are examined to uncover dialectical relations, followed by further examination of the social wrong in stage 3.

Fairclough's (2013) *Stage 3: Consider Whether The Social Order 'Needs' The Social Wrong* examines whether the social wrong needs or can be changed (Fairclough, 2013). Here, we examine what is required in society to sustain particular discourses. For this study, this leads to

inquiring why the social wrong - the problematic HCO work environments - is needed and what is supporting it. It examines the dominant discourses in HCOs and a deeper understanding of the social wrong.

Stage 4: Identify Possible Ways Past The Obstacle involves developing strategies to overcome the social wrong by changing the discourse. Here, the emphasis is on analyzing dialectical relations between semiosis and other elements to provide opportunities for change (Fairclough, 2013; Wodak & Meyer, 2016).

4.2 Data Collection

My data collection included document analysis and semi-structured, in-depth, one-on-one interviews with NEs working in HCOs.

4.2.1 Inclusion Criteria

To be included in this study, participants were defined as the highest administrative level nurse in an HCO in Ontario, responsible for all nursing services and administrative and/or operational responsibilities. They work or had worked in an HCO that provided homecare nursing services in Ontario. They were currently or had previously been licensed[11] as an RN. They were able to respond to the interview in English. They make complex decisions about the organization as a senior leader or executive and may report directly to their organization's President, Board, or Chief Executive Officer. Participants held various titles within their HCO, such as Chief Operating Officer, President, Director, or Vice President. NEs who had retired, left

[11] Licensed is with an 's' as this is the spelling used by the College of Nurses of Ontario

the profession or held other employment during data collection were interviewed if they met the criteria. While participants were required to communicate their experiences in English or French, all conducted their interviews in English.

4.2.2 Recruitment

There are 57 homecare organizations listed in Ontario by various organizations[12]. CDA does not require a specific minimum number of participants (Wodak & Meyer, 2009). I used criterion sampling, where all participants must have had a similar experience (Polit & Beck, 2012). I anticipated I would need 15 to 20 participants to obtain the breadth and depth of data needed for analysis. A final sample size of 17 NEs was obtained due to the availability and interest of the participants. See Appendix B for the Research Summary Log.

Recruitment was done through professional associations (i.e., the Canadian Association of Self-Employed Registered Nurses [CASE RNs] and the Community Health Nurses of Canada [CHNC]) and my professional networks to maintain the anonymity of the participants. Professional associations received a cover email asking them to distribute a recruitment script in English and French that could be distributed through their listserv or posted on their social media pages (i.e., Instagram, Twitter, LinkedIn and Facebook accounts]. The professional associations also received a copy of the consent form. See Appendix C and D for the Study Information Sheet

[12] I could access various lists of homecare organizations in Ontario, from Home and Community Care Health Services, Home Care Ontario, and CASE RNs.

and Consent Form (in English and French), Appendix E for the Recruitment Cover Letter, and Appendix F and G for the Recruitment and Social Media Script (in English and French).

Participants interested in partaking in the study contacted me directly by email to express their interest. Eligible participants were taken on a first-come, first-served basis. Clarifying any aspect of the study and providing the Study Information Sheet and Consent Form was done via email. I answered their questions and provided participants with details about the purpose of the study, time commitment, risks, benefits, and ethical considerations.

Participants' signatures were obtained once their questions were answered satisfactorily. They signed the consent form and emailed a copy to me, which I cosigned and returned a copy to them. An interview was scheduled, and a time and place were agreed upon. The consent form was reviewed with participants at the beginning of the interview. The interview then proceeded.

Study participants' rights were regularly reiterated during the interviews (e.g., the right not to answer questions, answer them off the record, or withdraw at any time without justification). NEs interested in the study were invited to inform other potential participants in their personal or professional networks.

4.2.3 Documents

Eight documents were chosen for analysis. They focused on nursing and healthcare leadership, professional development, and guidance from relevant Ontario, Canadian, United States, and international organizations used by NEs in Canada. The research participants mentioned these documents, and I was aware of many of them due to my previous work on nursing leadership at the Canadian Nurses Association. Six of the documents are produced by provincial, national, and international nursing organizations, and one is used by the Canadian

College of Health Leaders [CCHL], which provides professional development certification for healthcare executives. See Appendix H for a bibliography of the documents analyzed.

4.2.4 Interviews

Participants completed a socio-demographic questionnaire before the interview to capture demographic information. See Appendix I for the Socio-Demographic Questionnaire. I interviewed a total of 17 participants. I conducted second interviews with four participants to address findings that emerged during the initial interviews. See Appendix J for those additional interview questions. One participant sent me two emails after our initial interview after further reflection on the discussion topics.

I used semi-structured interviews and probing questions to stimulate participants' "discursive self-positioning" to encourage their vocabulary use (Fairclough, 2013, p. 131). Questions within the guide were developed based on the research aim, questions, and theoretical frameworks. See Appendix K for the Participant Interview Guide.

At the time of this study, a global pandemic was occurring, prohibiting face-to-face interviews. Therefore, with the consent of participants, I conducted interviews with 15 NEs through Microsoft Teams or Zoom virtual platforms approved by the University of Ottawa for research purposes. Due to the unavailability of internet connectivity, I could not conduct interviews with two participants using the virtual platforms. I held those two interviews on the phone without video recording, thus limiting my data collection to verbal statements and no visual cues. I could audio-record the interview with Participant 14; but I could not audio-record the interview with Participant 16 due to technical issues. I took handwritten notes; therefore, the transcript was not verbatim. Thus, all but one interview was transcribed verbatim.

4.3 Data Analysis

As a methodology, CDA does not dictate a specific data collection method. It incorporates qualitative methods to examine texts that are not just powerful because of the words spoken or written but as a result of the context within which they are used, who uses them, and how they are used (Fairclough, 2013; Wodak & Meyer, 2009). CDA involves an iterative process where data is continually re-examined, centering on critical reading and location of textual or visual data (i.e., interview transcripts, documents, pictures, and film). CDA contributes to research by analyzing emerging discourses, their relations, and how they are operationalized (Fairclough, 2013). He proposes three types of analysis to identify interconnections, patterns, and disconnections by looking at the relationships between texts, processes, and context:

1. Discourse as text (description, including verbal and visual texts).
2. Discourse as discursive practice (interpretation of the written word, how it is spoken, and what is observed); and
3. Discourse as social practice (explanation of the socio-historical conditions governing the processes). (Fairclough, 2013)

The study of discourse as it relates to power is integral to my research. By exploring the processes and relations in HCOs, we can better understand the interrelationships of discourse and power of NEs within the context of HCOs (Fairclough, 2001). Assumptions or ideologies shape, change or maintain social relations of power within HCOs and how an NE is seen through the reoccurrence of ways of working and behaving. Using CDA allowed me to look at ideology as a modality of power (Fairclough, 2013).

Fairclough's three levels of analysis identify dialectical relations to understand how textual data, discourse, and discourse as social practices interpret and convey power, knowledge

and ignorance relations. Each will be described in the following sub-sections. This allowed me to move between and among the levels of analysis. I looked for the relationships between texts, processes, and context (Fairclough, 2013). There is a complex interplay of these three levels of analysis that do not exist independently but overlap. Consequently, each step was repeated several times to refine the analysis. It is important to note that the same process for the following three steps was used for interview and document analysis.

4.3.1 Discourse as Text

Fairclough (2001) defines text as a product and part of discourses, including written, spoken, and visual textual data (Fairclough, 2013; Fairclough & Wodak, 1997; Wodak & Meyer, 2009). The words used in texts demonstrate identity, beliefs, priorities, and agency within a community through syntax, metaphors, and rhetorical expressions (Fairclough, 2001; Fairclough, 2013; Wodak & Meyer, 2009). This involved textual analysis to identify dialectical relations to understand how language interprets and conveys power, knowledge, and ignorance relations. As noted in Chapter 1, Fairclough's CDA allowed me to analyze semiotic relations between discourse and social structures, problems, ideologies, and identities, focusing on issues related to power and knowledge in HCOs (Fairclough, 2013; Wodak & Meyer, 2016).

I started analyzing my data while conducting the interviews and reviewing documents. Through this preliminary but careful reading of the data, I extracted the main idea of the text segments line by line. I linked them to other segments within individual transcripts and across transcripts. I aimed to identify the core meaning of the texts analyzed. I specifically looked for spoken or written vocabulary patterns, including semantic relationships between sentences, whether an active or passive voice was used, and styles, metaphors, and rhetoric within the texts. I looked for texts or voices that were included or excluded and what authority they had. I looked

for experiential values of the words used, how they are ideologically challenged, their relational values, how words are expressed, the value placed on their use, and the use of metaphors (Fairclough, 2001). Specifically, when analyzing discourse within the documents, I explored who the intended audience was, such as nurses at all clinical and administrative levels, health care professionals, and executives in general.

4.3.2 Discourse as Discursive Practice

At this level of analysis, I looked at how existing discourses were used to convey ideas and convince (Fairclough, 2013). I looked for social events, practices, and networks occurring in HCOs and what was taken for granted and omitted. For example, in this study, I explored what is occurring in HCOs, such as autocratic discourses, which may benefit from maintaining the epistemic positioning of NEs. I examined whether the text was situated within a genre chain. Fairclough (2003) defines genres as "a way of acting its discourse aspect" (p. 216). More specifically, genre chains refer to how a text is organized and linked to another, whether there are differences or consensus among texts. Authors of texts often rely on existing discourses to assign meaning based on their assumptions, pre-existing knowledge, and uptake of certain discourses. Value assumptions, such as economic discourses, were explored by examining how words were used and how sentences were composed to demonstrate values and attitudes (Fairclough, 2013). For example, healthcare, nursing, and for-profit HCOs reflect the neoliberal approach of homecare. Therefore, it was important to analyze how those discursive practices shaped social practices and how discursive practices shaped social practices. Those reciprocal relationships demonstrated an interdiscursivity.

4.3.3 Discourse as Social Practice

Analyzing discourse as a social practice involves looking for societal structuring elements that affect the text being studied (Fairclough, 2013). For example, I examined how discursive elements were used or avoided and analyzed textual data for agency, knowledge, ignorance, and power strategies. I also related these findings to broader socioeconomic influences, such as the congruence of these organizational configurations concerning neoliberal goals and imperatives. I looked for representation of social events and discourses within the texts.

Throughout Fairclough's three steps of analysis, I paid attention to the underlying ideologies that produce multiple, and at times competing, discourses and knowledge in HCOs (e.g., performance, safety, efficiency) and how they play out in NEs' epistemic register. The flow and association of ideas (e.g., describing events or attempting to retrace lines of accountability) were examined (e.g., how certain discursive or epistemic elements are mobilized, omitted, linked, or presupposed); semantic repertoires, polarizations, contradictions, and discursive shifts were noted. Strategies of legitimacy and authority used to amplify or dismiss interpretations were examined as regimes of truth and ignorance. Power, knowledge and ignorance configurations that govern NEs' work and discourses in HCOs were sought. I looked for the dominant discourse construed as most relevant by the participants and myself and within documents, noting what was made irrelevant, by whom, and for what intent.

CDA allowed me to identify and contrast NEs' subject position as epistemic agents alongside the HCOs' socioeconomic mandates. I examined the experiences, perceptions, discourses, and inferences of the NEs. I was able to expose power configurations and ideologies which govern the epistemic spaces of HCOs. Using Fairclough's three types of analysis, I

examined historical, political, and social constructs that sustain power structures and position certain organizational actors, such as NEs, as certain kinds of knowers in their HCOs business.

4.4 Reflexivity

Reflexivity is a technique researchers use to observe themselves and how they interact with the research process. It considers the researcher's self-reflection by looking at a researcher's personality, role, and positionality in their study (Band-Winterstein et al., 2014; Brackenridge, 1999). It is essential to recognize where I fit within this research's power, knowledge, and ignorance relations and what boundaries between the researcher and participants needed to be established to mitigate ethical concerns (Dickson-Swift et al., 2006). My social location as a white woman in a senior position in nursing influenced this research. I have had relatively easy access to the positions I sought, often having the choice of multiple nursing positions to choose from with employers. However, my nursing experience was often bureaucratic in nature and function.

I recognize that I am allegiant to the participants through being a nurse, having a solid commitment to the profession, and having worked in nursing leadership positions for the past twenty years (Brackenridge, 1999). The shared identification of my being a nurse facilitated the interrelation between myself and the participants. Further, the number of NEs working in HCOs in Ontario is limited. As such, I already had professional relationships with many of the participants. I knew certain participants through our professional and volunteer activities as RNs before this study. Participants that I did not know were referred to this study through shared acquaintances and professional nursing associations, as I discussed in section 4.2.2. No matter how small these relationships were, they meant I had some baseline knowledge about the participants' backgrounds or the context in which some of them worked. I was cognizant of these

contexts for some of them, but not all. These factors allowed me to (1) harness the trust and boundaries I already had with participants I knew and (2) build trust and boundaries with participants I did not know early in the research process to avoid their suspicion or concealment (Dickson-Swift et al., 2008; Dickson-Swift et al., 2006). This was accomplished by remaining composed and empathetic during interviews. Additionally, while I no longer have an employment status similar to the participants', they were informed of my work history at the beginning of each interview.

In this study, I position myself as both an insider and an outsider researcher. Participants readily identified themselves and me as RNs specializing in community health. My knowledge and connections with participants could have influenced their narratives, as some situated their responses within the context of our pre-existing relationship. There was value in some shared experiences of the issues, my having worked in homecare, understanding the funding issues associated with homecare, and understanding the positionality of homecare nursing compared to nursing in acute care settings. This provided a useful frame of reference between me and the participants.

This being said, I have never been in the position of a NE in a homecare organization. Therefore, not all experiences were shared. In addition to my professional experiences, I have accumulated knowledge through my nursing practice and policy development work. I gained knowledge and insight through my own experiences of being faced with competing discourses and competing agendas in nursing. My experiences sensitized me to some of the dynamics that occur in homecare that I aimed to investigate and understand better. However, I am aware that those experiences are mine and that there are nuances regarding the nurse executive epistemic space of which I am unaware.

Fairclough emphasizes that the spoken word cannot be analyzed independently of corresponding “gestures, facial expression, movement, [and] posture” (Fairclough, 2001, p.22). I supplemented the interviews with memo-taking and field notes completed immediately after each interview. See Appendix L for the Interview Summary Form. I captured visual cues such as grimaces, laughter, and pounding on the table in my field notes and when transcribing my interviews with the NEs. I kept contemplative field notes to capture observations and reflections on the verbal and non-verbal demeanour of the participants, adaptations of the interview questions, changes in focus and transitions in participants' discourse during interviews, and critical reflections by myself throughout the study. Memos included feelings and thoughts that helped me make sense of the study data.

My positionality shaped how I collected and analyzed the research data. In conducting this research, I am also fully an epistemic agent. I could reproduce ignorance mechanisms by missing nuances, forgetting details, or perpetuating what is dismissed or omitted. Oftentimes, I was not surprised when participants spoke about their issues and challenges in navigating nursing issues, which at times created a risky sense of ease and confidence. However, through conversations with my advisor and thesis committee, I was challenged to not be blinded by the realm of what is familiar to me, and to push my analysis beyond the mental schemes about homecare that I have developed over the course of my career. Using Fairclough’s CDA approach also helped me in this regard, by calling attention to subtexts and participants’ discursive, epistemic, and identity moves that I, as a researcher, needed to follow and dissect.

I wanted the NEs to become engrossed in their stories and retain their power in the interview process. To facilitate a safe interview environment, I was responsive to the participants' verbal and non-verbal reactions (Brackenridge, 1999; Sampson et al., 2008). The participants

shared personal and professionally challenging experiences with me; therefore, debriefing occurred throughout the interviews as needed. The interview transcripts and documents were analyzed based on my social positioning, knowledge, and values (Chouliaraki & Fairclough, 1999). Interview transcripts and documents were informed by literature to seek clarity on emergent themes. To accurately portray experiences, I had my advisor review parts of the raw data.

4.5 Rigour

Rigour refers to the degree of care taken in the data collection, analysis, and reporting (Greckhamer & Cilesiz, 2014). During the interviews, I took the time to explore and obtain clarification of items that were discussed. For example, when the participants spoke to me as a nurse, they often said, “You are a nurse, you know what I am talking about.” I interpreted such statements as an attempt by participants to establish rapport with me as a fellow nurse, a colleague they knew, or someone who shared similar experiences. I upheld rigour by getting participants to explain those items in their own words so that I would stay true to their narratives (Leitch & Palmer, 2010). I paid attention to the accuracy of the transcripts as a component of rigour. Coding served as a reliability check and involved reviewing quotes by my supervisor and discussing them with my thesis committee. To ensure rigour, I supported themes that emerged from the data with multiple participant quotes.

I revisited my methodology and theoretical framework several times throughout the analytical process. I reread Fairclough’s work (2013) and key ignorance (e.g., McGoey, 2007; 2019; Perron & Rudge, 2016) and CMS (Alvesson et al., 2009) texts and had extensive discussions with advisor and thesis committee to help me move away from descriptive thematic analysis and undertake a more thorough use of CDA. I was as detailed as possible while

remaining concise and illustrative with quotes. While reporting, I also needed to be careful not to use codes that could identify a particular participant given the nature of the homecare sector where most NEs know one another.

4.6 Ethical Considerations

Discussing personal, organizational, and systemic factors that shape the experiences of NEs may position participants vulnerably in a system that already marginalizes nurses and offers little protection to persons in senior management positions. The research project, of which this study is a part of the product, received ethics approval from the University of Ottawa, Office of Research Ethics and Integrity, Project Name "Organizational Agents as Epistemic Agents: Re-examining Nurse Executives' Agency in Home Care Organizations," No. H-01-21-6379, 19/04/2021. See Appendix M. The *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2: CORE)* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, 2019) was fully respected.

Participants' identities and rights were protected at all times. Participants' names were collected for recruitment, communication, and obtaining consent only. Using online and telephone interactions for interviews offers the same trustworthiness as face-to-face interviews (Saarijarvi & Bratt, 2021). Alphanumeric codes were used on all documentation related to participants instead of real names and will not be disclosed in the findings or during dissemination activities. During the transcription of the interview, all identifying information about people and events (e.g., a distinctly identifying organizational change) was omitted or modified to eliminate the likelihood that the organization, and therefore the participant, would be recognized.

I was aware of the risk of potentially exploiting the participants' vulnerability for my gain. I created an alliance with the research participants to create a safe space. There were risks in this study as the in-depth sharing of participants' experiences could render the NE vulnerable, recalling events which might be distressing, as it was not known beforehand what information would be disclosed and how the participant would experience this disclosure (Streubert & Carpenter, 2011). If participants felt discomfort during or after the interview, they would have been referred to support services or encouraged to access their Employee Assistance Program (EAP). While this did not occur, if the participants required more than a debrief with me during or following the interview, I made myself available if needed.

The Information Sheet and Consent Form stipulated safeguarding the participant's identity and maintaining confidentiality and privacy of any information shared. See Appendix C and D. Participants were informed of their right to withdraw from the study at any time without negative consequences and without needing to justify their decision in any way. No participants withdrew from the study.

The participant's participation did not have a direct benefit to them. However, research suggests that interviews may have a therapeutic effect on participants, such that they can reflect on their journey with a sense of pride and willingness to use their stories and experiences to help others (Dickson-Swift et al., 2008). It allowed the participants to express their opinions about the role of NEs in HCOs. It will also serve to raise awareness about NEs' experiences.

All research data, including consent forms, interviews, password-protected digital data, and socio-demographic questionnaires, were kept securely under lock and key per the University of Ottawa guidelines.

This chapter discussed how Fairclough's CDA methodology has been used in this study. The following chapter will describe the findings of this study using Fairclough's (2013) CDA.

Chapter 5: Results

This chapter describes my results using Fairclough's (2013) CDA to analyze interviews with NEs, memos, field notes, and selected documents. Results revealed how overt and covert power, knowledge, and ignorance dynamics within HCOs and the healthcare system mediated organizational enactment of NE positions. Discourses were manifested in interviews with NEs and policy and guidance documents. I first present overarching results from the semi-structured, in-depth, one-on-one interviews I conducted with the study participants. I then present the four main themes and 12 sub-themes I developed by analyzing those interviews. Participants described the selected guidance documents and reports as relevant to their roles and responsibilities. My analysis of these documents is embedded throughout the themes. I then conclude the chapter with a summary of my findings.

As stated in Chapter 4, I interviewed 17 NEs. Participants were located across the province of Ontario in rural and urban areas and large and small municipalities. All participants were either in the position of NE at the interview or had previously been in that position. Ten participants reported to a CEO or president in their position as NE. Other participants were CEOs of an HCO (N=7). Of those who were the CEO, a number were independent business owners.

All participants interviewed identified as female. However, I did not request their personal preference for pronouns; therefore, I am using the pronoun 'they' throughout this study when speaking of an individual participant. Of the 17 participants interviewed, 15 identified as white, one identified as other, and one did not respond. All the participants stated that they had their RN license to practice. They explained that their positions as NE required them to have an active RN license.

Regarding education, 15 participants were graduate-prepared, with additional certifications in leadership or management (N=8) and various nursing specialties (N=6). When asked about their experience as an NE, most participants (N=11) had more than 11 years of experience as an NE in homecare. More than half of the participants (N=10) had held previous NE positions in other healthcare sectors, such as acute care. A summary of the socio-demographic data is in Table 1.

Table 1

Participant Socio-Demographic Data

Socio-Demographic Variable		*n*
Age		
	47+	14
	No response	3
Sex/Gender		
	Female	17
First language		
	English	16
	Other	1
Race/Ethnicity		
	Caucasian	15
	Other	1
	No response	1
Number of years as a NE		
	0-10	6
	11-20	3
	21+	8
Number of NE positions in homecare		
	1	8
	2-4	7
	5+	2
Number of NE positions in other healthcare sectors		
	0	7
	1-4	9
	5+	1
Highest level of education		
	Undergraduate degree	2
	Graduate degree in nursing (master's or PhD)	6

	Graduate degree (other discipline)	9
Types of certifications held		
	Nursing	7
	Management	7
	Other	5
License currently held		
	RN	17

Using CDA, I analyzed 21 interview transcripts from the 17 participants. I interviewed four participants available for second interviews to address findings that emerged during the initial interviews. See Appendix J for those additional interview questions. One participant sent me two emails after our first and second interviews with further reflections on the discussion topics.

The analysis of participants' interviews helped identify discourses that addressed this study's research questions. I analyzed discourse as text, discursive practice, and social practice, as discussed in Chapter 4. To analyze discourse as text, I examined participants' speech and visual cues by looking at the words they used, how they talked about a subject, and how they illustrated values and attitudes. I then used process analysis to look for discourse as discursive practice. I assessed how participants drew on existing discourses and social relations to convey their experiences and perspectives. Finally, I analyzed participants' interviews, looking at discourse as social practice and for social, historical, and political conditions and consequences governing the situation wherein the discursive practice was taking place.

Throughout this chapter, I highlighted varying discourses and discrepancies between the participant interviews and document analysis. As discussed in Chapter 4, I chose eight documents the participants mentioned they used for leadership education, professional development, and guidance on their roles and responsibilities as an NE. The College of Nurses of

Ontario and RNAO produced Documents 1, 2 and 3. The documents outlined standards of practice and conduct that are enforceable in Ontario. RNAO and CNA produced Documents 4 and 5 respectively, and the International Council of Nursing produced Document 6. All four nursing associations provide nursing leadership guidance or professional development leadership programs for nurses. Document 7 is a book used by the Canadian College of Health Leaders [CCHL] that provides professional development certification for healthcare executives. The final Document 8 is from the United States of America and addresses the future of nursing. See Appendix H for a bibliography of the documents analyzed. See Appendix H for a bibliography of the documents analyzed as outlined in Table 2.

Table 2

Documents used in Document Analysis

Document Identifier	Document (Author)	Description
D1	Professional Standards, Revised 2002 (College of Nurses of Ontario)	This practice standard puts forward seven professional standard statements for RNs and RPNs. One of the standards is leadership.
D2	RN and RPN practice: The Client, the Nurse, and the Environment (College of Nurses of Ontario)	This practice standard focuses on decision-making for nurses to provide safe and ethical care. One nursing factor within a practice standard focuses on leadership.
D3	Independent Practice (College of Nurses of Ontario)	This practice standard focuses on self-employed nurses who provide nursing services or operate their nursing businesses.
D4	Nursing leadership [Position statement] (CNA)	This CNA position statement discusses nurse leaders in all roles and senior executive roles. It addresses the need to develop strong NEs.

D5	CNE/CNO Governance and Leadership Initiative Role Description Framework (RNAO)	This framework emphasizes the roles and responsibilities of senior NEs in Ontario regarding governance and leadership functions.
D6	Nurses: A Voice to Lead – Invest in nursing and respect rights to secure global health (ICN)	This international document addresses investment in nursing leadership as a strategic and policy focus.
D7	Bringing leadership to life in health: LEADS in a caring environment: Putting LEADS to work. (Dickson & Tholl (Eds.))	This book is the basis for a one-year health leadership program run by CCHL for health executives from various disciplines.
D8	The future of nursing 2020-2030: Charting a path to achieve health equity. Chapter 9: Nurses Leading Change (Wakefield et al.)	The document addresses formal and informal nursing leadership focusing on health equity. It mainly argues that all nurses are leaders.

Results highlighted discourses related to the healthcare system's hierarchical order that specifically situates homecare as secondary to tertiary care. Participants conveyed their positioning and tension as NEs in homecare as executive and nurse. They also reflected on how they managed the flow of information within HCOs and the broader healthcare system. As mentioned, I identified four main themes and 12 subthemes from my analysis of the 21 interview transcripts, documents, field notes and memos:

1. Homecare as an Ambiguous Healthcare Space
    1.1. Dissonance About Homecare Funding and Accessibility
    1.2. Nurse Executives Balancing Business and Clinical Ideologies
    1.3. Use of Indicators and Tools
    1.4. Influence of a Global Pandemic

2. Defining the Nurse Executive in Homecare
    2.1. Nurse Executives as Carers
    2.2. Societal Beliefs Towards Nurse Executives in Homecare
3. Managing the Flow of Information
    3.1. Demonstrating the Relevance of Nursing
    3.2. Having a Seat at the Table
    3.3. Managing Expectations
4. Managing Positionality
    4.1. Professional Representations
    4.2. Strategic Alliances
    4.3. Sense of Self

Most participants were cautious in how they responded during the interviews. They controlled the flow of information by requesting reassurance that what they shared during the interview was confidential. By ensuring confidentiality, participants exemplified their discretion in what they shared. The reoccurring use of the question "Right?" to me by participants suggests a need for validation. Participants often used the phrase "As you know," speaking to me as a nurse who had been in senior positions. They strategically directed the interview, clearly framing themselves and me as nurses. They often pointed our profession out, recognizing that I was a nurse. Participants often qualified their responses by confirming that they were doing nursing and being a nurse.

5.1 Homecare as an Ambiguous Healthcare Space

In this study, participants reflected on the positionality of homecare within the healthcare system. They contended that homecare, as a healthcare sector, was ambiguous and confusing

compared to tertiary care settings. They often indicated that this was due to the complexity of the governance of homecare by the provincial government. I previously described the governance and organization of homecare in Ontario in Chapter 2. As mentioned, HCOs in Ontario can be private health care businesses and not-for-profit charitable organizations. Participants revealed that this complex structure created misunderstanding among the public and health professionals about accessing homecare, especially those working in tertiary and primary care. Participants sometimes identified their responsibility to educate others about homecare. This created challenges for participants. I discuss this in the first theme. The second sub-theme examines how participants attempted to balance clinical and administrative ideologies in their roles as NEs. I also address the subsequent tensions participants encountered, given the challenges of managing the delivery of nursing care within a for-profit organization. In the third sub-theme, I discuss how participants expressed using standardized indicators and tools in HCOs. They described how they navigated using these tools to fulfill their organizational responsibilities. The fourth sub-theme addresses the impact of the COVID-19 on participants.

5.1.1. Dissonance About Homecare Funding and Accessibility

In this study, participants expressed incongruencies in understanding homecare as a healthcare service by the general public and healthcare providers that did not work in homecare. Specifically, they raised the widespread perception that all healthcare services were free and paid for by the government, creating a suggestion of entitlement. They contended that this view was

sustained by the discourse of universal healthcare[13] in Canada. “I think a hangover from the Tommy Douglas years, where healthcare, the *Canada Health Act*, where it [healthcare] has to be approved by the government and has to be paid for by the government of Canada” (P02, lines 394-397).

Many participants described the historical context of healthcare being free, universally accessible, and funded by the government. Participant 02 exposed an expectation that the government’s role was necessary. However, later in the interview, they described the relationship between the provincial government and the healthcare system as problematic:

> They’re [provincial government] a gatekeeper. And they're the approver of the care. And yet, that's [healthcare is] the only one that exists in all the various ones [other sectors, i.e., education] have to work under this model, which to me is ridiculous. … I don't know whether government really gets it. They don't have a lot of respect for service providers, which I find. (P02, lines 384 – 402)

By stating that the government approved healthcare services, Participant 02 positioned the government as an entity with agency. They expressed frustration, which further personified the government by providing it with attributes of lacking respect and knowledge but having control

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[13] Universal health coverage is defined by the World Health Organization as “all people hav[ing] access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care.” (World Health Organization, 2023**)**

over others, specifically healthcare services. Using the term gatekeeper further suggested a negative portrayal of government entities, which I will discuss at the end of this section - this personification of the government which appeared in interviews with several participants.

Building on the discourse of free healthcare, participants described how people receiving care did not understand that homecare services must often be paid for privately. This was often a challenge for self-employed participants. Document 3 guides to nurses in independent practice and defines this role. It states that "nurses in independent practice are those who are: self-employed for the purpose of providing nursing services, and/or operating their own nursing business" (D3, p.3).

Despite the justification of this nursing role, self-employed participants felt supported by the nursing regulatory body. Participants who were self-employed or did not receive contracts from the provincial government indicated that this created difficulties for themselves:

> Obstacles would be the assumption that healthcare is free. And we [NEs who are self-employed entrepreneurs] are fee-for-service. Although because we are registered healthcare professionals it is depending on what benefits they [people receiving care] have. … But [those] people were thinking, well, no, I'm entitled to this [all healthcare]. I shouldn't have to pay, and it should be covered by OHIP[14] [the Ontario Health Insurance Plan]. (P15, lines 57 – 61)

[14] OHIP is the provincial health insurance plan that covers some, but not all health services in the province.

This participant's use of the word "entitled," suggested the judgement of patients who supported the discourse that all healthcare was assumed free. It also suggests the idea of unrestricted access to healthcare, which is contrary to the typical functioning of the healthcare system. Participant 15 identified themselves as self-employed, owning an HCO, and situating homecare as a business, which disputed that discourse.

Participant 15 and other self-employed participants noted that people who required homecare services not covered by government funding relied on private healthcare insurance, personal funds, or an income tax benefit to pay for those services. Participants explained that this created inequities in the delivery of homecare services they oversaw. Consequently, participants expressed concern about many people not having the financial resources to pay for the quantity or quality of homecare that they or their family members required.

Another self-employed participant noted that healthcare providers in hospitals were reluctant to recommend HCOs to people requiring homecare services if the HCO was not listed as receiving government homecare contracts: "The biggest issue is providers feeling like, providers in hospitals anyway, feeling like they can't recommend private services because you have to pay for them. That's the biggest barrier [to the business of homecare]" (P03, lines 101 - 103 first interview). The participant contended that healthcare providers in hospitals perpetuated the discourse of healthcare being free. While Participant 03 did not support that discourse, they appeared resigned to accepting it. The contention conveyed during participant interviews that hospitals believed that HCOs receiving public funds were somehow "better" than those relying solely on private payment created a false understanding of the homecare sector.

Only some participants in the study felt prepared or supported to advocate for a change in the discourse of publicly funded healthcare, especially nursing homecare. They often aligned this

with the discourse maintained by CNA and RNAO that made private nursing services less acceptable. For example, CNA stated that nurses had an obligation to advance publicly funded healthcare: “An historic role in the push for publicly funded health care…as a basic human right” (D4, p.5). However, a contradictory discourse circulated by RNAO makes self-employed nursing visible through a practice standard for nurses in independent practice. How societal beliefs affected self-employed participants is discussed further in section 5.2.2.

Participants, in HCO’s that regularly received government contracts indicated that there was little front-end investment required for HCOs, as most of the funding was required for service delivery and care. They raised a different view about HCOs, that of being cost-effective:

> I actually am in the private sector. In healthcare, in particular, it is an interesting concept. And especially [in] our particular area [homecare] where there's not a lot of capital that you need, there's not a lot of front-end investment, a lot of it is in service delivery and care. (P17, lines 64 - 66)

Participant 17 positioned HCOs as cost-effective because they are situated in the private sector. This created a contrast with tertiary care, a healthcare sector that is publicly funded and requires considerable financial investments. Participant 17 exposed the tension between HCOs and other healthcare sectors. In thinking about Fairclough, this participant’s use of words such as “capital” and “front-end investment” demonstrate intertextual discursivity. We see a particular terminology style that nurses do not typically use. The participant draws from the economic discourse that positions the HCO in the private sector as a commodity. This language situates homecare within the discourse of neoliberal healthcare.

Another participant described the tension concerning a hierarchical or class structure within the healthcare system:

> Government is very much lead by a sector and hospital model. [I am] very surprised by the lack of their [government's] understanding of homecare considering the volume of patients. [It is] very short-sighted and short thinking by government. People need care in the home to prevent hospitalizations. Homecare is where people want to be – we have complex clients. … I get frustrated from the provincial level [of government] with all of the bureaucracy. (P16, lines 47 - 57)

Participant 16's use of the term "short-sighted" was strategic. They contended that restricted thinking was detrimental as it needed to address the aging demographics and subsequent increasing volume and acuity of people requiring homecare in the future. This narrative about the government was not unusual among the participants in this study. Participant 16 considered the government unable to see things clearly despite the number of people requiring homecare services. This discourse also suggested that the government needed more creativity or foresight.

Many participants described the bureaucracy and coordination required by the provincial government. They positioned this bureaucracy as problematic. One participant stated that the government is not making any effort to inform people about the availability of insurance to cover nursing care in the home:

> They've [the government] made zero [*emphasized zero*] effort to inform people about third-party insurance, which could help them stay at home, and also relieves some of the burden off the system through the coverage of third-party insurance and private providers. (P03, lines 28 - 31 second interview)

Participant 03 assumed the government's role to educate the public about homecare coverage. Other participants indicated that the limited funding from the provincial government meant that people eligible for homecare only sometimes received all of the required services. In the above

quote, Participant 03 problematized the government, noting that the government needed to take responsibility for educating the public about funding options that could alleviate pressures on the healthcare system. Later, Participant 03 again positioned the government as problematic when they described healthcare as a "political beast". The participant created a separation between healthcare, government, politics, and business:

> Healthcare's political, that's what I think about it. It's a political beast. And so a lot of it doesn't make business sense perhaps. But I think it's a political animal. And I think that's why we [nurses] see a lot of the things that we do. … They [the provincial government] don't make it part of their routine to educate people. It's not in their documentation. It's not on their website. (P03, lines 23-28 second interview)

When discussing healthcare as a political structure, "a political beast," Participant 03 employed familiar rhetoric implying the negative features of the government's control over healthcare. They expressed that the government needs to have business sense. The participant revealed complex power dynamics by strategically situating HCOs and the public together as short-changed. Another participant reflected on the lack of power among nurses to change the government's control over healthcare:

> I think that we [nurses] don't have a huge choice of how much government involvement there is, because it's a foundational value for Canadians to receive healthcare. And in Ontario, homecare is government-funded, thank God. But I think that there is room for improvement and looking at the context of individuals or communities, money can be spent or redistributed. (P09, lines 219 – 223)

Participant 09 reiterated the discourse that healthcare is a Canadian value. However, while noting that homecare receives funding from the provincial government, the minimal funds provided is not mentioned. The participant projected the government as a positive entity that is essential to homecare, while at the same time contending that the situation is not all good and requires improvement. They imply that the involvement of the government in homecare is necessary. The participant does not distinguish between government involvement and how the government makes decisions. As we saw with Participant 03, this participant shows knowledge of the problem but does not express personal motivation to promote change.

As we have seen in previous quotes, participants described HCOs as private organizations that receive public funding. The following participant mobilized the common belief that private organizations are better than publicly funded institutions. They positioned publicly funded institutions as lacking efficiency:

> I believe in collaborative competition. And as long as you do good work, it shouldn't matter where the money comes from, in my experience, and this is just my opinion. Based on my experience, publicly funded [healthcare organizations] are not as sharp as those that are privately owned. Simply because if you're privately owned, you have a harder role of it to demonstrate that you're actually doing good work. You're also having to manage your money much better than those that are publicly funded. (P11, lines 13 – 17)

There are several points to consider in this participant's discourse. The use of "collaborative competition" is contradictory. As noted in sections 5.1.2 and 5.4.2, participants reflected on the competitive nature of homecare among the NEs and the HCOs. Participant 11 softened the concept of competition by combining it with collaboration to nuance the usual conflictual nature

of the term. A second discursive move by Participant 11 positioned the public sector as “not as sharp” or innovative and, therefore, a burden compared to those privately owned as victims, having “a harder role of it to show that you're doing good work.” The notion projected by the participant is misleading. It implies that these two types of organizations are entirely distinct. The involvement of public funding was not visible and was excluded from their narrative. The participant then expressed some disdain for the public sector while benefiting from it. They also noted that government oversight diminished their ability to work.

One participant mentioned that underfunding did not allow creativity in delivering clinical care within the HCO. They described this as often leading to the delivery of patient care that was task-oriented:

> The funding model doesn't reward you for thinking out of the box, they [the government] reward you for excellence in patient care, which is fair enough, because that's what they have to be. If you don't have excellence in patient care, then you're not going to have good home health nursing. But it changed a lot from really kind of basic homecare to almost hospital in the home, the level of acuity, the level of expectation of clients that what they would pick up, oh my God, because they didn't, stuff was not funded. (P12, lines 153 – 159)

This participant personified excellence in patient care as necessary but also suggested conflict in defining excellence. They implied tension between excellence and acuity, where determining excellence in care was challenged by the increased acuity of people receiving homecare. Participant 12’s description of the funding model established it as a living entity. CNA reinforced this concept of thinking outside the box, which described nurse leaders as "creating vibrant, exciting practice settings" (D4, p. 4). However, what made a healthcare setting exciting and

vibrant and for what purpose was not expanded on in the position statement, which was last updated more than a decade ago.

A familiar premise emerged in interviews with participants where they described homecare as intricate and confusing, which participants saw as restricting access to services from HCOs. Participants described people who only received a predetermined amount of hours of homecare services that were covered by government funding. Participants indicated that many people had to prove their eligibility for government-funded homecare. Case managers in Home and Community Care Health Services then determined if a person were eligible for homecare and how much they could receive. However, participants noted that the eligibility criteria for accessing government-funded homecare services were unavailable to healthcare providers and the public.

Participant 14 exposed the complexities of the insurance policies and accompanying bureaucracy while appearing to direct blame reflexively toward the government:

> The biggest obstacle was the [government] in the logistics of paperwork that must be done, for insurance companies, for the coverage for patients. So you have a sick patient – they're palliative and the doctor wants to support the patient by putting in private care. So let's say the husband puts in the paperwork and the doctor fills it all in, then we send it to the insurance company. The insurance company comes back and says, "Oh you didn't fill out this line properly, fill it out again by the doctor and send it back." What happens is the insurance companies don't want to pay you even though it's like any other insurance claim of any sort. So they are one of the barriers - the insurance companies' policies in themselves… It's very stressful for patients that are going through whatever they're going through at the time, as well as the families. (P14, lines 41 – 60)

Participant 14 positioned the government and insurance companies as creating the biggest obstacles to covering nursing costs for people requiring care. Insurance companies, which are private entities, require the completion of “paperwork” by people receiving homecare services. This created barriers for those people and their families. The participant reflexively reverted to the prevailing discourse that blamed the government even as non-government entities created difficulties.

As Participant 16 mentioned earlier, the government worked within a model that supported hospitals. Other participants reflected on the hierarchical positioning of hospitals to HCOs. They discussed the historically low positioning of homecare within the hierarchy of all the sectors within the healthcare system. This was despite decades of policy documents released in Canada that positioned homecare as an effective cost alternative to acute care. One participant expressed the hierarchy of homecare as compartmentalized: “And homecare was over here, in this little bucket over here [gesturing to the side]. I would have assumed there was some crossover because for me, it's all in the community. Homecare is very separate from everybody else, very separate” (P12, lines 47 – 51). The participant described the dominance of the acute care sector within the healthcare system and positioned homecare as overlooked and invisible. This discourse, which propagates society, was a surprise to the participant.

In addition to Participant 12, other participants, such as Participant 11 in the quote above, compared private healthcare with the public sector. They relied on the common discourses in society that position the healthcare sectors in specific ways, building on the assumptions that tertiary care is necessary and requires extensive public funding. Participants accept these discourses to influence their understanding of the healthcare system. Participant 01 noted that there were philosophical differences between the hospital and homecare:

> Just the philosophy behind home health care. It just is very different from the hospital sector. And it's also a part of the sector that touches absolutely every other part. So acute care, social services, homecare, community care, primary care. So it's a very exciting and dynamic environment. (P01, lines 27 - 30)

They positioned homecare as a holistic type of healthcare. This reflected their nursing identity and knowledge. This participant expressed an understanding of integrated healthcare. However, other healthcare providers do not necessarily accept this concept since the healthcare system does not function that way. Later in their interview, Participant 12 expressed their agency by highlighting the need for them to educate others:

> I was consistently surprised at how little the healthcare system [healthcare providers in the other sectors] knows about homecare. … they know nothing about homecare, and they know nothing about managing it. And so I was consistently surprised at people who I would have thought would have understood, that who sometimes talk a good talk, about how important homecare is and community health and all this bullshit, and they have no idea. They just have no idea. So it's consistent and constant reminding, explaining, creating stories. (P12, lines 579 – 586)

This participant described the healthcare system as a unique entity, providing it with attributes of ability and knowledge. Discourses such as the relevance of nursing for homecare services often informed the stories that P12 crafted to educate others. Being able to recount stories as a way of demonstrating their knowledge to justify the appropriate allocation of nursing resources worked to the participants' advantage. P12's strategies to use stories can also be seen as a way to harmonize situations.

Participants described homecare as a critical healthcare sector that minimized peoples' hospital time. They expressed the importance of discharge planning within hospitals. However, participants also disclosed that those individuals working in hospitals needed more accurate knowledge about the transition of patient care from the hospital to the home. They disclosed scenarios wherein healthcare professionals had limited knowledge about homecare delivery, what services were covered by the government, and which were not. They often used those scenarios as the basis for their stories when explaining homecare to other healthcare providers. They acknowledged that this often placed people receiving homecare in confusing or dangerous positions with potential outcomes of readmittance into the hospitals:

> The people in the community that we help, our families or individuals, that are feeling that they're just lost in the system. And with discharge planning there's big issues with transitional care, so that's where homecare would come into place. Now, in my opinion, you can't pinpoint any specific area of whose fault it is. If somebody falls through the cracks … and they're told somebody will give you a call within three hours of getting home, and they don't get a call and they don't know what to do, so they end up going back to the hospital. (P15, lines 24 – 31)

This participant mobilized their nursing and executive identities back and forth. They personalized how they expressed their relationship with people receiving homecare when speaking about "our families or individuals," which we often see in nursing. However, the participant does not assign ownership to errors and mismanagement in the transition of people into the homecare system. We may interpret this as protecting the HCOs by not faulting the organization for delayed homecare visits for new individuals. However, it also acts as a personal protective mechanism, as the participant is in the role of NE with oversight for those clinical

services that may not be functioning appropriately. This exposed lack of knowledge among people receiving homecare, but also lends to the question of who is maintaining that ignorance.

Participant 12, who earlier described the lack of knowledge about homecare by healthcare professionals, also noted this lack of knowledge by the public: “People had no idea how important homecare was until they needed it. And they just kind of thought, Oh, well, it'll be provided. Well, no. They had no idea. Absolutely no idea. And they still don't” (P12, lines 765 – 767). This participant reinforced the public opinion that people do not consider exploring healthcare options until they need them.

Another participant provided an alternative assumption that people were thinking about homecare prior to needing it, positioning their narrative within a managerial discourse to describe people:

> I think the people who need to be educated are the healthcare consumer, the patients, doctors, and other nurses. It's nice when they refer to us, but at the end of the day, the patients have to see the need, and have to be willing to pay for it. So educating people, we still have people who think the doctor tells me everything I need to know. Right? So as long as we're working with that consciousness, we're going to have people who aren't looking to us [Registered Nurses] to answer their problems. But I think educating Canadians is the key piece. They don't really expect a lot from healthcare, they don't even think of themselves as a healthcare consumer. So they don't realize their tax dollars are going to healthcare. It allows them to get a second opinion, allows them to ask questions allows them to expect better. (P03 lines 505 - 514 first interview)

This expectation of the public taking the initiative to understand healthcare services is curious. By creating this alternate reality, the participant is serving many interests. A more knowledgeable

public sector that understands the nuances of healthcare funding and taxation augments healthcare professionals' status and potentially diminishes the government's authority and role. It may also perpetuate the stereotype of the government mishandling healthcare spending and keeping the public ignorant of their healthcare management.

Beyond focusing on people requiring homecare and healthcare professionals in acute care, participants took different stances in attempting to change the rhetoric about homecare. One participant situated homecare in a position of influence and necessity for society: "I think, to society, homecare nursing is the key to that bridge between hospitals and long-term care. It's that, it's that bridge" (P13, lines 241 - 242). While this assumption conflicts with some earlier quotes by participants, it demonstrates optimism, which we see reflected by another participant who went further in need to establish a different discourse.

A different viewpoint, using a managerial discourse of value-added, was adopted by another participant. They focused on establishing the value of homecare as a sector to nurses:

> So you have to find voice, to leverage the value-added that exists in the home and community care sector that doesn't exist in the hospital world. Because the differential in pay, if that is a decision-point for someone, they will likely go to the higher paying employer. Right? But they need to understand the uniqueness of the environment where there's a huge potential for a nurse to work to full scope, to work within a community, to be part of making a difference in the lives of individuals to resume and remain in their homes. I mean, that kind of thing doesn't translate to dollars per hour, right? [pause] … So you have to find those opportune times to be able to show the value of a professional practice environment that enables a nurse to make a decision to work here versus work in the hospital. (P09, lines 183 – 191)

Despite being flawed, this participant expressed agency in attempting to leverage homecare as an attractive employer. In effect, all participants endeavoured to create a new and positive discourse about homecare through various narratives directed toward different audiences.

It is worth noting that many participants positioned the government as a homogeneous discursive category. The government became a central part of many participants' narratives, depicting the government as an object rather than a complex entity. They portrayed it as the cause of many of the problems in homecare. Participants personified the various government levels and branches, simplifying it into a black box. They described the government as a gatekeeper, providing too much oversight, needing to understand homecare and allow creativity. Participants provided the government with motivation and intent to lack knowledge and attentiveness, suggesting a simplified narrative for complex decision-making.

5.1.2. Nurse Executives Balancing Business and Clinical Ideologies

This theme builds on the dissonance about homecare participants described in the previous theme. The government's role in overseeing homecare services impacted how participants accomplished their work. This discord about homecare created tensions that affected participants' experiences managing clinical and operational functions in an HCO. This theme reflects the balance that participants managed between the commercial and social values of working in an HCO. They often expressed this as attempting to ensure the delivery of quality care within a homecare sector that was poorly understood. Participants described situations where homecare was meant to be profitable. As one participant stated: "A for-profit [HCO] has to operate with the reality that there's got to be money on the bottom line" (P04, lines 356 – 366 first interview). As we saw in the previous section, participants criticized the government for putting constraints on staffing and service delivery through limited budgets. As another

participant noted: “Money is going to [government] infrastructure versus patient care” (P14, lines 202 – 203). This complication raised challenges in how participants managed their roles and responsibilities in the HCOs. It also created tension between their business and clinical ideologies.

To balance these ideologies, participants projected the importance of having a solid nursing identity. As previously mentioned, many reflected on their experience as a homecare nurse and how it had an impact on their responsibility as an NE to invest resources in clinical services in the HCOs:

> And I would probably say, originally, I did invest very significantly in the clinical space. Probably, again, as a nurse, and with my experience as a visiting nurse, it was clear to me the confidence to believe you're providing quality care is as good as how you educate and provide the tools to the frontline staff that are providing that care. (P17, lines 186 – 190)

However, this participant also projected the challenges of focusing exclusively on clinical services as an NE. Many participants raised the need to look more broadly at the delivery of services. They described it as an expectation of their role as an executive, positioning it within the organizational culture of the HCO. This created further tensions between the participant’s two identities. For example, one participant indicated that complications arose due to being contract-based, creating problems when investing in clinical resources: “The ability to influence and make practice change in this environment is complicated, because it’s a contract-based environment. You can’t pull a nurse from doing home visits to do an in-service because there’s nobody else to back them up” (P09, lines 40 – 43). This participant proposes an interesting contradiction. While some HCOs receive government contracts and associated funding, they charge people privately for homecare services. Participants’ statements in section 5.1.1 that funds

come from private sources are overlooked. This participant deflected blame from themselves and the HCO for the lack of innovation in nursing practice models in the HCO. They created the assumption that a contract-based environment created limitations. This participant's statement supported the statement that Participant 11 made earlier about privately funded HCOs being more innovative than publicly funded ones.

Other participants demonstrated agency by establishing HCOs that were nurse-led. One participant noted that this was not an easy endeavour, describing governmental policies as obstacles:

> I got a lot of pushbacks from [the provincial government] … [with people in the provincial office saying] there's no way that model [of a nurse-led business] is ever going to work ... I realized that I knew that I was going against the status quo, but I also realized that things need to change for nurses to answer the public and to bring in a better way to do care. (P14, lines 62 – 66)

This participant attempted to change the everyday discourse of a nurse not being self-employed. They expressed agency by venturing to become self-employed. They took risks going out on their own. The pushback they spoke about was the reluctance of the government to provide contracts to a fully private nurse-led HCO that would not require complete oversight by the government. These participants challenged the common discourse that nurses are employees, not employers. This was important to the participant in improving nursing homecare services.

The following participant reflected on the challenges they experienced within the HCO to balance the care provided to a patient based on funding. They inferred that there was a risk to the profitability of the HCO:

> I think we were challenged all the time. Because ethically, any decisions involving client care, or in an organization like that, automatically means that you're balancing. … because we were funded to do certain things, right. ... We weren't saying that we're funded to do five visits, only do three, and we'll charge you for that, that would never have ever, ever have come up. What would have come up is that we're funded to do five visits, and it should actually be 20. So then what do you do about that? So then that means that somebody then starts advocating for the client. (P12, lines 699 – 708)

Participant 12 exposed the quantification of patient care as an organizational norm within HCOs. This created ethical conflict with the participant, as they moved back and forth between clients' and the organizations' needs. The participant displayed the tension between their nurse and executive identity when they noted that "someone" should advocate for the client, clearly positioning care as a priority.

Many participants expressed this tension. One participant described tensions arising from the parent company's interpretation of homecare. They described the limited resources provided by the parent company for nursing services within the HCO:

> So we had few resources, comparatively, no sharing of resources. [pause] I would say they just didn't understand homecare. They just wanted us to operate like long term care. And it just doesn't work like that. Right, bricks and mortar versus human beings. So that was just a constant challenge. There were attempts to actually reconcile, well, it wasn't really reconciling values, we were told that we were going to adopt [the parent company's] values. So there was a lot of that kind of autocratic behavior. And lots of decisions that we weren't efficient. That just sent people spinning, that created unsafe situations and operations. (P04, lines 292 - 300 first interview)

This participant displayed conflict between the different knowledge and discourses circulating in the HCO, describing contradictions in how they and the other executives defined patient care. Their narrative suggests underlying power dynamics as certain care interpretations were exposed across the HCO under the guise of harmonization. This made it difficult for the participant to work with limiting budgets and led to what they interpreted as unsafe decisions.

The participant noted a disparity that created a division between their and the organization's values. Their narrative reflects feelings of being forced by other executives within their HCO to adopt business values, regardless of how mismatched they were from their nursing values and perspective. In the second interview, Participant 04 showed the conflict and tension they experienced when overseeing the delivery of quality patient care:

> I was always challenging them [other executives in the HCO] at the quality-of-care level. And it's not that I didn't understand business. I totally get business. But when it comes to patient care, for me, the business had to be second. … The conversations about this imbalance [of] quality versus business. … to understand it wasn't a clinical-operational divide. I was always at loggerheads with [other executives in the HCO] trying to get what operations and care needed so that they can meet their budget. (P04, lines 170 – 176 second interview)

Here Participant 04 expressed agency in trying to interrupt the inaccurate understanding of homecare. They attempted to shift the HCO conversations and insert nursing knowledge into decision-making. However, their agenda continued to be constrained. This created conflict for the participant. Later, in a follow-up email, the participant described the organizational structure within the HCO that created challenges to achieve their goals: "I think this type of structure (with direct reports at the front line) would have expedited the appreciation between clinical quality

and administrative operations and would have provided more opportunity to achieve the necessary goals" (P04, first email). This participant indicated the divide between clinical and administrative knowledge. We also see the participant portray a need for more influence to change the traditional organizational structure.

Participants reflected on the competitiveness between HCOs. They addressed how the public and private funding of homecare perpetuated this competition. They suggested that one of their responsibilities was selling the HCO's specific homecare brand to the public, other healthcare providers, and healthcare sectors. The following quotes illustrate the discord between the need to protect business interests while delivering care, with one participant questioning the reason for this divide:

> As you know, homecare has been a competitive business space and continues to be so today. Historically, very little information about how care was delivered was shared across the industry. (P04, first email)

> I think there's always been a natural tension between when professional practice and the operations function are separated. And I think it's as successful as the individuals that you work with. But we are in the business of operationalizing clinical care and clinical processes. So I never understood the divide. (P08, lines 67 – 72)

Participant 04 positions the discord between business and clinical ideologies of HCOs within a historical context. Participant 08 questioned the traditional conflict between business and care ideologies, suggesting this historical context. In both narratives, we see indications that the current challenges in homecare reflect the lack of historical knowledge and substantiate current conditions.

Many participants reflected on their values as nurses when expressing the importance of their clinical ideologies. As we saw earlier, Participant 04 attempted to align their nursing ethics to the values of the HCO. Participant 17 also reflected on this value proposition:

> I moved into homecare because people were still in control of their lives. … This is the value of respecting people, and their how they want to live their life, and where they want to live their life, and how we enable that. (P17, lines 261 – 266)

This discourse of caring is common in the homecare sector. As I discussed in Chapter 2, caring is in the standards of practice for homecare nurses. I will discuss it further in Section 5.2.1. The following participant enacted their agency and identity as a nurse by expressing respect for how people wished to receive care. Their narrative also exposed the tension between their identity as a nurse and executive:

> I think in homecare, we're incredibly privileged to be going into people's homes and be there as their guests and being invited in when they're at their absolute best or their absolute worst. And you don't mean a crisis. And when they're at their most vulnerable. And they're completely exposed from a human sensitivity perspective, I think that's a huge privilege. So of course, as a nursing leader, I think we're very privileged to be trusted in that way. And we should take it seriously. Right, we should take that very seriously. (P08, lines 497 – 504)

Earlier, Participant 08 expressed a strong relationship between clinical care and the business aspects of working in an HCO. In this narrative, they positioned the relationship between patient and nurse as one with respect and humanity, taking it beyond a business association. The participant highlighted the caring values of nursing within their NE role. Participant 08 enacted

their agency and identity as a nurse by demonstrating respect for how people wished to receive care. They promoted these values as both a nurse and executive.

When other participants contended with an imbalance between the administration and clinical functions of the HCOs, they also positioned it within their nursing values and ethics, making connections between their sense of self and purpose as an NE:

> As long as I have a sense of purpose that I am making a difference, it gives me energy. … Nursing is a responsibility. Lead by the person. … And that is sadly not being delivered. … It is not ethical that we are not able to provide homecare that people need. (P16, lines 87 – 98)

Many of participants' narratives reflected their nursing values as foundational to their roles as NE. While Participant 16 did not specifically address the values of the HCOs in their narratives, they did suggest tension when discussing their values within the financial constraints of the HCOs.

Participants also described needing to understand and see the connection between their role and the HCO's mission and strategy. They reflected on the challenges they felt toward their nursing values when trying to balance their business and clinical ideologies:

> I do think as a nurse you bridge the administrative with the clinical. And so, when you see substandard clinical care, I think we have a heightened awareness of that, and certainly a professional, legal, moral obligation to speak out about that. [more demonstrative – speaking with hands] And so, I think nurses are perhaps more sensitive to really watch what is going on. I think we have that ability to because we've been trained to look at everything in its totality, whether it's a person, and certainly as a healthcare leader, you look at it as a system. And so you look at what works well, what's

> functioning well, and what's not functioning well. And I think that's the way that we're trained, I think, as nursing, as nurses. (P01, lines 142 - 151)

This participant showed the advantage of having administrative and clinical knowledge, suggesting a more holistic knowledge base among NEs. They also reflected nursing and executive agency by contending that NEs need to take responsibility for recognizing "substandard clinical care" and bring it to the attention of others. This was often evident when their position included responsibility for clinical care but did not include authority over the hiring of staff:

> What's tricky is that you're responsible for changing people's practice. That's basically what you do everyday, right? You're, everyday [emphasis on everyday], you're changing the way people do things in their clinical work, yet you're not in a position of authority over them, right, they do not report to you, you do not manage their performance, you did not hire them, you do not fire them. (P07, lines 234 – 238)

For Participant 07, the dual role of executive overseeing clinical operations was necessary, despite experiencing ongoing challenges. These challenges were sometimes situated in their position within the line authority of the HCO's executive team. Participants described the authority of the Chief Executive Officer to delegate the NEs' roles and responsibilities. This created a challenge for many participants in establishing and maintaining an organizational culture that blended operational and clinical outcomes in the HCO. One participant described their imperative to align themselves with the mandate of the HCO, later expressing conflict and tension of being a nurse and executive:

> I've always said with all leaders, the organization comes first. So you better believe in the organization, or it's going to be a problem. … If you're a leader, at any level, and you're looking at what's good for the organization, you will always come up with the right answers for them. … to think about the organization first. (P17, lines 328 – 340)

Participant 17 expressed the tension between their role as nurse and executive, highlighting the relevance of their executive identity to the HCO. They appear to set boundaries for themselves, sheltering their nursing identity to survive in the HCO as an NE. Another participant equated this tension to a tug-of-war created within the HCO, highlighting the ideology of business, with profit-making in the HCO as the exemplar:

> When the [CEO] made the decision to actually divide the whole organization back into regions and create district operation leads, the fun became, again, right, because all of those operations people were concerned primarily about the bottom line, and not really about operationalizing care. (P04, lines 83 – 86 first interview)

This participant highlights the hierarchal organizational structure within the HCO. They expose the Chief Executive Officer's line authority to clinical and operational decisions. The participant suggests controversy in this decision-making method as it minimizes the clinical functions of the HCO. For participants, these often went beyond the oversight of nursing services, including operational administration.

The following participant described the autocratic organizational structure of the HCO: "If the CEO has a vision, and the CEO believes in the vision, then the management team and the organization is going to back it up. The leadership is everything" (P07, lines 308 – 309). Participant 07 noted deference to the CEO's visions. However, they also suggest an opportunity

to influence decisions by convincing the CEO to invest in their idea. The participant experienced the tension of being an executive and embedding nursing into their HCO.

In this sub-theme, participants exposed the discourse of commodification. They revealed this when they conveyed feelings of unease about the challenges of balancing business and clinical ideologies. Participants evoked tensions that they experienced in working in HCOs. They justified the homecare sector's economic value, expressing their executive identity while embedding their nursing values and identity. They linked the commodification of homecare to issues of access, human and financial resourcing, and quality care. Tensions occurred as participants worked to embed nursing into their roles and responsibilities as an NE.

5.1.3. Use of Indicators and Tools

Participants discussed how the government used performance and productivity technologies as formal mechanisms to monitor HCOs' organizational outcomes in this theme. In turn, these measurement methods were used within the HCOs to monitor aspects of the NEs' ideological commitments. Participants described how they navigated using standardized indicators and tools in HCOs to fulfill their organizational responsibilities. They often described these tools as mechanisms to quantify the delivery of quality patient care. They noted that these tools used by their organizations measured their performance and success as NE. In contrast, participants also defended using indicators and tools to obtain and maintain a credible branding of HCOs. They noted that this was necessary to appeal to people receiving care, their families, and staff nurses in the HCO.

One participant explained that much of the discourse within HCOs was concerned with measurement, economic benefit, and quantifying care. They described the government

requirements for reporting as causing divergence of the HCO business model with the provision of clinical services:

> Where you get stuck is when you've got a business model that you actually have to survive. And then you've got the balance between the business model and providing homecare services … because the problem [with the HCO] was that, and all of the private ones, is that the government demanded certain reporting, it demanded this, it demanded that, and, and the organization had to pay for it, it wasn't the government [that] paid for it. (P12, lines 168 – 177)

The government justified and remunerated the HCOs for the services delivered based on outputs. Another participant's narrative suggests intertextual chains linking HCOs with reporting structures such as Key Performance Indicators:

> It's a very metric driven environment when you are contract performance, right? So KPIs [Key Performance Indicators] become your normal language, whereas it may never have come across in the hospital. You might have been talking about incidents, or numbers, or percentages or some sort of numeric value, but not necessarily a Key Performance Indicator. But now, that's mainstream language, in the home environment. (P09, lines 162 – 167)

This participant's narrative conveys their acceptance of these processes as defined by the government to promote efficiency. Participant 09 reflected on the constant oversight that NEs were subjected to despite being in an autonomous profession. KPIs were one device that structured the logic and the operations in HCOs, among others. Participants also identified the electronic health record as a necessary tool to mitigate risks. The previous narratives reflected the

dominant discourse in homecare created by the government, which had socialized participants to see that indicators and tools were necessary for organizational and professional prestige.

These participants also presented a conflicting discourse on whether these tools were considered helpful to patient care. The indicators and tools moved the focus of homecare nursing onto tasks. Moving away from the rhetoric of task-based nursing has been longstanding and was reflected in participants speaking about the care that met the needs of people receiving care. However, participants' narratives created a different vernacular, one of efficiency. This notion of efficiency perpetuated task-based nursing by quantifying and fragmenting care. This created tension for participants because they moved away from the values discussed in the previous section.

Beyond those output measures used to quantify patient care, participants noted that the government did not define what constituted good care. Absent from participants' narratives was how they defined good care. However, the rhetoric of indicators is familiar in the healthcare discourse. Document 2 uses the term "quality care" extensively to describe the type of care that nurses deliver but does not define what constitutes a quality indicator or who develops those indicators, despite their use as outcome measures for client care: "[The] goal of professional practice is to obtain the best possible outcome for clients" (D2, p.3). The document also situates indicators as a professional standard for nurses, including NEs: "The indicators include responses to legislated and regulatory requirements, client and community relations, accreditation, and health and safety requirements" (D2, p.13).

This lack of definition created a variety of issues for participants. They noted that trying to define 'good' or 'quality' care was complex and exacerbated their challenges in promoting clinical care to the other HCO executives. It also allowed differing entities to construct

definitions that suit them based on their ideologies. This created more tension for participants. For example, one participant reflected on the link between outcomes to establish efficiency and the use of HCO funds to deliver care: “Using resources to invest, you [the NE] want to make sure you have great rigour for why, and you have good outcome measures for why you're using those dollars for that” (P17, lines 157 – 158).

In addition to Participant 17, many participants used the language of quality or good outcomes to demonstrate coordinated and streamlined care, with the implicit assumption that everyone in the government and HCOs agreed on what it meant. The participant mobilized the discourse of good outcome measures to establish better performance and economic viability by the HCOs. However, participants did not propose counterarguments that addressed the limitations of using indicators that scholars have raised extensively worldwide.

Participants positioned the importance of using standardized metrics to ensure good patient care. They explained that reporting to the government was a requirement to ensure that the HCO merited ongoing funding contracts:

> In the course of doing those proposals, it was an opportunity to explain what is it they [the staff nurses] do? How do you cost it? Why do you cost it? So the government could understand the relationship between cost and outcome. Early in the stage of outcome measurement I would say those RFP [Request for Proposals / contract] documents were a chance to do that. (P06, lines 24 – 27 second interview)

Participant 06 used the RFPs to convey knowledge about the contribution and the value of what staff nurses did. They also used them to educate the government about how nurses are a “good kind of cost.” This participant used the paperwork to their advantage by injecting nursing knowledge and perspectives into the bureaucracy. Given how most participants described

government oversight and bureaucracy negatively, as we saw in previous sections, participants still saw opportunities to complete outcome measurements.

The rhetoric of processes, focusing on outputs, and oversight via tools framed how the participants felt compelled to view patient care. In effect, these tools and indicators restricted the definition of nursing and perceived negative impacts on the HCO as a business. Another participant indicated the importance of data collection and documentation of data to interpret nursing care to the other executives in the HCO:

> As you know, we [the nursing department] want quality documentation, we want to make sure our patients are getting the care they receive, we [the NE] want to make sure our staff are supported. Those are the underlying things that are always there. (P10, lines 260 – 262)

This participant conveyed the coexistence of two identities, nurse and executive. Their quote highlights the importance of documentation as a strategy to support nursing services. Participants used these various tools and indicators to benchmark nursing services. They also used them to ensure that other executives in the HCO understood what was occurring during home visits by nurses. Another participant explained that the HCO receiving funding was dependent on quantifiable nursing tasks:

> So what became really clear was that the funding that we got, and the funding that other agencies would get was very much based on Mrs. Jones needs a dressing done five times. And this is what you do. You go in, and that's what you do. And you're given the funding for that. You're not given the funding for anything else. So when we talked about other more creative things that could be done in the community, they were still being done. But

> we had to find money from other places, like foundations, or from these community boards. (P12, lines 96 – 103)

This participant noted that funding received from the government was dependent on the quantity rather than the quality of nursing care required and received by a patient. Providing more homecare services to a client required the NE to seek private funding sources. Participants disclosed that access to nursing homecare was important. This participant described the complexity of providing homecare for an individual who may require more than the measured eligible care funded by the government.

In this sub-theme, participants expressed that data collection through tools and indicators was an essential strategy for establishing and maintaining nursing services within the HCOs. Indicators and tools structured thinking, making homecare services appear fixed. Participants chose to use those indicators to make decisions and ensure the funding of nursing services. Using organizationally accepted tools, participants could make homecare nursing visible to the other HCO executives. Consequently, participants exemplified the existence of a technocratic discourse in their roles as NE and in the HCOs. They could justify clinical care by quantifying it and following rules set by the government. These structures and procedures limited the participants' creativity. The government used performance and productivity technologies to control and measure organizational outputs and outcomes. These tools, such as KPIs and EHRs, generated specific knowledge about homecare nursing and, therefore, can be considered epistemic tools.

5.1.4. Influence of a Global Pandemic

As mentioned in Chapter 2, this study occurred during the COVID-19 pandemic. Many participants described how the COVID-19 pandemic heightened and re-exposed problems raised

over many decades and their challenges with the provincial government. The government established policies that required unchallenging enforcement by the HCOs. The study participants' reflections exposed the political dimension of their role. Participants expressed concern that the pandemic was further depleting homecare resources, which they had already described as under-resourced, as discussed in section 5.1.1 (Lefebre et al., 2020). One participant indicated that, despite the pandemic and the associated need to keep people at home, the provincial government did not increase funding to HCOs:

> The Ontario government and I think I said this, but I want to reinforce it. The Ontario government has absolutely, based on the notable absence of any increase in funding for homecare, tells me that they don't see this [homecare] as of any value. Like you put your money where your mouth is, and they haven't put the money there. And my concern is that it took the long-term care crisis with COVID for them to actually go, 'Oh, we didn't know this was happening'. Yes, you did. You've had reports for the last decade saying how bad it is there. And so my concern is that it's going to happen again and we're going to lose even more nurses. (P11, lines 306 – 313)

Participant 11 exposed how the pandemic revealed ongoing situations where the government decided what information to disclose. The government contended they were "just discovering" how bad the homecare situation was despite years of warnings from NEs. Consequently, competing discourses were circulating, with the government trying to control the narrative in ways that allowed them to escape their responsibility. Knowledge and non-knowledge were embedded in those narratives, placing healthcare professionals and the public in positions to decide which narrative to believe. Participants emphasized the importance of NEs compared to other executives in HCOs during the pandemic. They positioned the NEs as visible and valuable

to homecare. One participant reflected that the COVID-19 pandemic provided opportunities to shift how nurses and NEs were perceived by others, especially in the homecare sector:

> I think this pandemic has demonstrated there's no such thing as just a nurse anymore. I think that nurses have really risen to the occasion, really demonstrated the importance of our role during something like a pandemic. And in the end, its's in the weirdest kind of ways, it's been a great year for us, right? In the craziest kind of ways. No one ever would say I was just a nurse. [laughing] (P08, lines 373 – 377)

Participant 08 appears to infer that it being visible as more than "just a nurse" was challenging. They expressed their identity, legitimizing themselves as a nurse. The clinical nursing component becomes important in this narrative as P08 reveals their nursing identity. Other participants suggested that being described or seen as "just a nurse" diminished their professional value. Another participant expressed surprise that nurses were leading, as compared to physicians, raising the hegemonic discourse within society that positions physicians as 'natural' leaders in healthcare:

> Just reflecting on all of the communications during COVID, that went out to our [the HCOs] staff, went out to our clients, and we [NEs] did so much communication, like everybody does, right? Town halls and newsletters, and just so much communication. And it was all my crisis to manage. And so they [other executives in the HCO] could see that the organizational response was being managed by a nurse. … And so I think that was interesting, probably for people is to see that these crises were led by nurses. … I just think it's great to see some of these nursing leaders take the reins during a crisis, when everything's a disaster, and I think it's particularly interesting in homecare, because we don't have physicians in homecare. (P07, lines 357 – 371)

Participant 07 took sole responsibility for managing communications within the HCO to educate staff and clients about the pandemic. This strategically positioned the participant at the forefront of the HCO. However, it also explicitly tied this positioning to the crisis context brought on by the pandemic, as opposed to a regular occurrence for NEs. The participant also alluded that the absence of physicians in the homecare sector may facilitate nurses' ability to take on a more significant role. In doing so, the participant alluded to the traditional view that physicians play a central, leading role in healthcare organizations, in keeping with a biomedical view of care systems.

This belief, perpetuated by the government, other healthcare providers, and the public, reflects what this participant saw as structural social practices within the healthcare system which the pandemic broke down. The international Document 6 makes a similar observation when indicating that NEs are not "full partners with physicians":

> "Nursing leaders and leadership have not always been valued. There are often barriers to nurses participating as full partners with physicians and other health professionals in high-level decision making and policy development. One of the root causes of this is often the belief that nurses are "functional doers" who just follow instructions." (D6, p.26)

One document positioned the pandemic as offering specific opportunities to NEs. Document 6 supported the narrative that the pandemic had amplified the visibility of nurses: "The public has started to recognize and appreciate the skill, scientific knowledge, leadership, and professionalism of nurses" (D6, p.11). The document suggested that the public only now realized nurses' clinical and professional contributions, deploying a process in its infancy despite decades of efforts by nurses to secure meaningful recognition. Despite this one phrase, there is no

additional text to discuss nursing and the pandemic. The document also does not offer any strategies to advocate for sustainable change.

Participants noted that the pandemic highlighted the need for homecare and, more explicitly, nursing in homecare. They also highlighted the need for nurse leaders who understood clinical health issues beyond the administrative needs of the HCOs. One participant expressed the opinion that the pandemic provides visibility to the NEs to have a voice to discuss the issues affecting the homecare sector:

> Then the pandemic hit. And in a way it was a godsend, because having somebody with a healthcare background leading the charge, and the feel of a pandemic was kind of a smart thing to be happening, especially a nursing leader, right. So it just made things easier to move forward. And to get things done. (P08, lines 63 – 67)

Participant 08 aligned the pandemic as an opportunity to expose their nursing identity, seeing a healthcare crisis such as the pandemic raising the profile of NEs. The participant also exposed their previous challenge to advance their agenda, noting how this moved the importance of nursing services to the top of the HCO's priorities. However, despite the heightened visibility of nursing, another participant highlighted the magnitude of the workload: "I think the entire organization realizes that without that [nursing] team, we would never have gotten through COVID. That team held the organization up. Honestly, they [the nursing staff] were phenomenal. And they worked like dogs, honestly" (P07, lines 313 – 315).

Like Participant 08, this participant recognized that nursing became highly visible within their HCO. However, P07 presents a paternalistic attitude disconnected from nurses' needs. The expression of gratitude by the participant towards the staff nurses for working "like dogs" contends that the nurses work very hard. However, it also alludes to the fact that this heavy

workload is often accompanied by an outcome of struggling to cope or manage. Another participant used similar paternalistic language to convey the expectation of staff nurses having to put more time, effort, and energy into their jobs during the pandemic: “During COVID. I just, [pause] I am so proud of them. They work so hard. They're so committed, it’s phenomenal” (P17, lines 235 – 236).

These two participants positioned the pandemic as an opportunity, speaking praise but not discussing the horrific impacts on nurses at the point of care. Again, we see a participant expressing gratitude for ‘phenomenal’ work beyond the expected workload. However, another participant noted that the challenges of working during the pandemic outweighed the benefits for NEs:

> There have been times where my staff or I have had very little sleep for weeks, weeks, or months on end. And I think that does take its toll. And I'm seeing now with a pandemic as well. Just a huge volume of really very talented staff retiring. And I just think, those are some really strong nursing leaders. And I just think, oh, my gosh, there's going to be such a gap in the system. (P01, lines 229 - 234)

Aside from increased workload, one of the challenges brought on by the pandemic was the nurses’ role in debates among the population once vaccination mandates were issued. The following two quotes demonstrate the conflicting discourses that were circulating in society about implementing mandatory COVID-19 vaccines in the healthcare system and the general population:

> It is our job to meet people where they're at … I just feel in my leadership role is to try to help people keep their minds open [about the vaccine]. (P03, lines 613 - 626 first interview)

> And there's been a lot of discussion about mandatory vaccinations the last couple of weeks that I just said: mandatory vaccination, that is what we're doing, it is what makes sense. (P17, lines 236 – 238)

While Participant 03 encouraged staff nurses to 'keep an open mind' about COVID-19 vaccines and not to be drawn in by misleading information, Participant 17 articulated their need, as the NE in the HCO, to make a clear decision about mandatory vaccination that would protect staff, the people receiving care and their families. These participants knew the conflict and decisiveness needed to address this issue.

Many participants evoked the visibility of the acute care sector during the pandemic, which stood in stark contrast to the visibility of the homecare sector, as seen earlier. One participant explained that despite the lack of human resources in homecare, the NEs in HCOs were directed by the government to reassign staff nurses to work in long-term care facilities, overwhelmed with COVID-related staff shortages:

> If we think that homecare is part of the healthcare system, and in the pandemic, I think it's pretty obvious that the safest place for people to be, was at home. But what were we requested to do? We were requested to deploy our staff to long term care facilities and for all the right reasons. But then there's nobody in the community and then everybody's screaming bloody murder because we don't have enough staff in the community. (P08, lines 298 – 303)

During the pandemic, the government did not consider the homecare sector as a solution to protect individuals, their families, and the broader population. Instead, it became a reservoir of personnel to compensate for pandemic-related staff absences and attrition in other areas, particularly long-term care. This was regardless of the needs of people requiring homecare, the

sustainability and safety of care delivery and the transferability of nursing skills across care sectors. Limited resources in homecare compared to other healthcare sectors were due to the hegemonic positioning of other sectors in the healthcare system. The government reinforced this rhetoric due to the context of the crisis. The participant exposed two conflicting narratives. There was an expectation that homecare was an obvious solution for patient safety. However, health authorities felt justified in depleting the homecare sector of its nursing staff despite these decisions' compounding effects on the longstanding invisibility of this sector compared to others.

In this sub-theme, participants revealed how they were both visible and invisible. They exposed how the government, and the public did not understand the values and contributions of the homecare sector. The public and other healthcare professionals value nurses. However, participants also exposed how ongoing challenges were still evident and seemed only visible to themselves and those who worked in homecare. Participants also suggested that efforts to educate the government and the broader public about the importance of homecare yielded limited results and was an ongoing effort they took on as NEs, and that became a core feature of their role in the HCO.

5.2. Defining the Nurse Executive in Homecare

This theme addresses how participants perceived themselves and how others perceived them. In section 5.2.1, participants discussed nursing being a female-dominated profession and how this perpetuated the discourse of nursing as a caring profession. In section 5.2.2, participants expanded on these perceptions that were based on expectations by people in society. This impacted their roles and responsibilities as NE in the HCO. Participants exemplified what people, the government, and healthcare providers in other healthcare sectors knew or thought

they knew about NEs in homecare. These perceptions created tension for participants between their nurse and executive identity.

5.2.1. Nurse Executives as Carers

Participants reflected on how nursing is a female-dominated profession and is portrayed by society and the nursing discipline as a caring profession. They explained that because most homecare nursing occurred in peoples' homes, other healthcare professionals assumed that nursing in homecare was easier compared to acute care. Participants reflected that homecare nursing was perceived to involve a different acuity and complexity than care provided in institutional settings. For participants, this perception made the lack of understanding of homecare nursing apparent. They defended the complexity of this care by emphasizing that homecare nurses worked alone without the availability of immediate support that they would have in an institutional setting.

Participants indicated that nursing programs in the HCO provided care for people who required complex, technological healthcare interventions. They identified the physical and emotional risks to staff nurses working for HCOs. Participants noted that these risks were more significant than in other healthcare sectors. They pointed out that nurses working in hospitals, in contrast, did not work in isolated environments and were close to other healthcare providers, managers, and security personnel.

Participants often moved between accepting and arguing against a discourse of gender inequality. For example, Participant 12 explained the lack of diverse opinions through gender, which could quell creativity if nurses were not prepared to be "shut down":

> P12: I was still consistently surprised at the role of men and women … and we will let them [men] still, kind of take control of the conversation in many cases.

Researcher: Is there an example that sticks in your mind?

P12: Oh, well, just every group, every group I see, with every group, every week, and I find it fascinating, because the men will often talk more, and sometimes it's good. But a lot of times I think they talk to hear themselves talk. And then women come in more tentatively. Not all women, and I think nurses are getting better at that. But that would be another thing for leadership that you have to know how to interject. And how to talk in those in that those forums that you've got 40 people around the table. Nurses, that's a really important leadership role.

Researcher: So why do you think that is?

P12: I think it's [nurses being tentative and not taking control in meetings] because it's an all-female profession. Mainly all females. And we're not supported or trained, or whatever the word is, to have different opinions. We're supported to have the same opinions. And so if you have a different opinion in a meeting, and those are often the most creative ones, you are kind of shut down, which is fine if you're expecting to be shut down. That's good, because then you can go back out a different way. But if you're not expecting that, it shut shop for the next few meetings. (P12, lines 599 – 619)

Participant 12 drew attention to their surprise that there continued to be a power differential between men and women in healthcare. They explain a situation that describes a delicate balance of power. Later on, Participant 12 noted the gender difference in how people communicated at the executive level in meetings:

So men, they're different in how they communicated, in how they presented themselves, and how they sat down, and how they took charge. Theirs is a very different way of

> being, I'm not sure what else to say. It's not as bad. And so I learned a lot from them. Actually, I learned a lot by watching them. Right? I learned how to sit down when you enter the room. How to enter the room. I thought I knew all this because I'd worked in executive positions before, but not like be aware. Because in [the HCO] when you're defending your budgets, and because it was private, so it was all very you know, how to be prepared how to substantiate what you were saying how to choose one thing that you were really fighting for, but maybe there was really something else there that you wanted. So it's that whole game, how to play the game. And I found a lot of times they were more willing to, what's the word, seem like the real expert, even though they didn't know and appear to know. The women were more willing to take the backseat and I would include myself in that, I learned not to because they would come across very forcefully and knowledgeably. And yeah, some of the women didn't. That's for me is where it's different. (P12, lines 236 – 251)

In addition to showing how difficult it was to navigate those meetings in the HCO, Participant 12 portrayed executive meetings as a game. They positioned the power within the men within the HCO and strategically looked to adopt their mannerisms to increase their visibility in meetings. Participant 12 also perpetuated stereotypes that suggested that men are “naturally” like this rather than being products of a society that values and accepts these demeanours in men but much less in women. Participant 12 appeared to accept that women do not “naturally” have these qualities due to their gender but rather that they have been socialized differently.

Another participant acknowledged the longstanding inequities in nursing. They noted that working in the homecare sector was a very ambivalent field for nursing practice:

> In my opinion, the whole gender, the pink profession, I think it's more blatant in a homecare environment just by the workload nurses are having to do. Being in positions and work environments that are, in so many cases, not the safest thing on the planet. The pay is absolutely horrible, and the benefits. … I think, [homecare is] the highest-risk sector. And on the one hand, I think it's the best sector for nurses to work in because you can work full scope. At the same time, there is minimal support or recognition. (P11, lines 299 – 306)

This participant used the term "pink profession," which connoted the inequality that nurses experienced through lower pay and difficult working conditions. This reinforced the view of the tiered organizational structure within the healthcare system that positioned homecare nursing as receiving fewer resources and recognition and seeing NEs as carers. At the same time, the participant noted that nurses in homecare had more independence than those working in institutional settings. We can also note the participant's contrasting views that homecare nursing was both a demanding and advantageous field of practice. While the participant acknowledged challenges within the homecare sector, they also projected it as an emancipated area for nurses, with understaffing, low pay, and minimal support as prices to pay for emancipated practice.

Participants used the metaphors "nursing is a calling" and "nurses are angels," highlighting the historical, stereotypical positioning of nursing as a virtuously caring profession and pointing to participants' internalization of such views. Participants expressed concern that this confronted their identity as a nurse:

> I do think people who go into healthcare and go into health professions [because they care]. I love people. So it's a calling and within that, that's why you respect them, you

> want to help them, it isn't about you, you're an enabler to all of that. (P17, lines 270 – 273)

However, another participant challenged that discourse, indicating that while NEs were compassionate, nursing was a competent profession:

> Nursing, even with COVID, I've been just incensed reading some of the stuff. I'm not a bloody angel. … I'm very competent, what I do, and don't call me an angel. Yes. And compassionate. … So is a respiratory therapist. … We [NEs] have missed that piece [to get the right message out about nurses]. And that is so important, when we're looking at a leadership perspective. (P11, lines 99 – 105)

Participant 11 resists the "angel" discourse. As we have seen, participants continuously balanced their nurse and executive identities. The image of an angel did not conjure that of an executive with management and financial acumen. Consequently, this participant saw this discourse as detrimental to their role and responsibilities. Another participant addressed this issue as both functional and dysfunctional. They highlighted the tension that such discourse caused within themselves, their relations with other executives, and staff nurses within HCOs:

> I do believe that my nursing background is a liability of sorts because of the public perception. And at the end of the day other healthcare providers are still the public too, so they also have, I'm going to call it a hangover or just a feeling, about where nurses belong in this system. And what we do and it's misinformed, but it's still the way it is. And so I think that [pause] that there's sometimes a risk in business in that people see us as not businesspeople. And that would be correct because we aren't typically trained that way. (P03, lines 163 - 170 second interview)

Participant 03 contended that their nursing identity was problematic due to the discourses of being a caring professional. In Participant 01's view, this discourse led to NEs being shamed by others for caring. They note that this compromises their identity as an executive:

> P01: It's almost like nurses are shamed, shamed for caring, shamed for caring about one another. And, as a nurse executive, you need to be thinking in terms of a business mind. And so if you're not, you're not as sophisticated as other leaders in the healthcare system. And so we've seen over the years, nursing executive positions being, really eroded. And so I think that we can't be seen to be caring about one another. Because that's a sign of weakness. You know, it's about a business mind. And it really is about always seeing the opportunity space for growth in power. And I think I've given a really cynical view of things, [chuckles] but that seems to be, [pause] yeah. [pause] Yeah.
>
> Researcher: And that's within nursing as well as beyond?
>
> P01: Yeah, exactly. But I think it does, it has eroded, really, the essence of what it is to be a nurse, [pause] to be compassionate and caring, and to be aware of others. (P01, lines 383 - 395)

The word "shamed" by Participant 01, which we will also see in Section 5.4.1, suggests embarrassment that is projected onto and felt by nurses. In the participant's rendition, dispositions for "caring" and "business" are in clear opposition, and there is little doubt about which is more valued. Using "eroded" points to a longstanding, gradual process wherein aspects of nursing wear away to satisfy demands brought about by the business environment.

In this section, we saw that historically entrenched lexicons of nurses as "carers" and "angels" caused the participant's identity conflict. They struggled with competing discourses.

One discourse from influential nursing associations and society defines caring as essential to nursing. That is, to be empathetic and compassionate towards others, especially people receiving care. The alternate discourse from the management field perpetuated efficiency, productivity, and cost containment. Consequently, participants struggled with being seen as executives in HCOs, where nurses, including NEs, were seen as clinicians.

5.2.2. Societal Beliefs Towards Nurse Executives in Homecare

Beyond participants defined as carers, they indicated that people receiving homecare, individuals in the government and other healthcare providers misunderstood the role and responsibilities of nurses in HCOs. They further reflected that the discourses circulating in society and healthcare organizations extended those discourses beyond staff nurses to NEs. They relayed stories about the weaker value of NEs that worked in HCOs. Self-employed participants also described their unique challenges.

Participant 14 challenged the current perception that they saw of nurses in society: “There's a culture of nursing and I just think it's time for nurses to be independent. I guess, I think, it's awful that we are managed and not allowed to be the professional” (P14, lines 400 – 402). However, they also presented conflict when saying, “I guess, I think,” evoking ambiguity, and a lack of confidence in their assertion. The use of “culture of nursing” implies longevity. They situated themselves, and all nurses, in a vulnerable position where they are, and have historically been, controlled by others.

Participants reflected that NEs in other healthcare sectors viewed the NE in homecare as less knowledgeable than those in the acute care sector. One participant described conversations they had with acute care leaders who said that the participant was wasting their leadership skills by working in an HCO:

> I've had some conversations with acute care leaders who have thought, “Well, why don't you come over, your skill set is wasted in home healthcare.” ... And I think it [homecare] does really need strong leadership, particularly nursing leadership, and clinical leadership. (P01, lines 69 - 73)

Positioning NEs in homecare as less knowledgeable than NEs in acute care exacerbated the tension many participants experienced between their identity as a nurse and executive. Participant 01 linked the discourse of an NEs skill wasted in an HCO to the broader discourse of the homecare sector. They imply that homecare is easier to manage than the acute care sector. Participant 01 suggests that the status of an NE is based on the perceived complexity of the environment they work in, reflecting that working in the homecare sector is complex. However, as seen earlier, homecare is only sometimes perceived as complex by NEs outside of homecare. It also suggests that nurses looking for executive positions are looking for that status. The implication is that HCOs require “strong” NEs, suggesting that recruiting NEs is difficult. Later in the interview, Participant 01 reinforced this perception by noting that the role of an NE in an HCO is very constrained:

> Researcher: People see NEs as a privileged, influential position … Do you think that's accurate? What are your thoughts?
>
> P01: I think it's a rather simplistic interpretation. Because I think they don't necessarily see the other pressures. It's, it's a very constrained role. I think from system and ministry, and then the demands come the other way. So I think it's the freedom that everybody would love to have, oh, [chuckles] that sort of fantasy vision. But in reality, I think that it's, again, it's misunderstood. (P01, lined 411-418)

The participant revealed how their role was constrained, limiting their ability to oversee the provision of care they deemed was expected by individuals, families, and those in other healthcare sectors. Considering Fairclough's (2013) CDA, the participant bases their assumptions on circulating discourses. This goes beyond concerns about a lack of understanding about the role but situates the role of NE within a restricted environment, the HCO. This lack of understanding about homecare by nurses who worked in hospitals extended beyond nursing to an overall lack of understanding about nursing in the community: "My nurse colleagues … just really, first of all, have the lens of inside the hospital. So these are nurses in the hospital, not really understanding community care, including me, I didn't know a lot about community care" (P03, lines 63 - 65 first interview). In this participant's view, how other NEs understand healthcare is restricted by where they are employed. This creates a very narrow knowledge of healthcare.

Participants described how the government mandated the NE role in acute care and public health, with written roles and responsibilities. However, the government did not mandate the NE position in the homecare sector. This could create situations where some HCOs may not have NE positions or could cut those positions due to budgetary concerns. Similarly, some HCOs could hire non-nurses to be responsible for clinical nursing services. This supports the discourse of the reduced value of the homecare sector and NEs in homecare. One participant described how HCOs had determined the need for NEs despite the position not being mandated:

> I think that the other thing that's interesting is it's [the NE] not a mandated role, the way it is in hospitals. There's nothing that says a homecare agency has to have a Chief Nursing Executive [CNE]. And so I think that if you look at most of the big homecare agencies

> that have nursing service, many of them will have a CNE position. So they've just decided to do that. Because it's leading practice. (P07, lines 440 – 444)

Participant 07 indicated that HCOs determined the relevancy of having an NE even though the government did not legislate the position. By specifying that many of the larger HCOs had NEs, the participant noted that HCOs were willing to employ nurses in those positions. Participant 07 attributed this to an understanding that this was "leading practice." They inferred that employing an NE reinforced, whether overtly or covertly, that having clinical nursing knowledge at the executive level in the HCO was beneficial. One of the documents analyzed supported this action that NEs should "gather more evidence on innovations and leading practices" (D7, p. 219).

Some participants identified themselves as self-employed or independent contractors owning an HCO. They described their rationale for setting up an independent practice: to fill healthcare system gaps and improve homecare access. Participants often projected both optimism and pessimism in their ability to influence improvements in homecare. While describing their intent to change the culture and discourses regarding homecare, one participant expressed their frustration over whether they were effective or not:

> I'm wanting to be in an influential position with nurses, to become self-employed, to be their highest possibility, to not be at the beck and call of other people when working for organizations that don't respect them and all these sorts of things. So I seek to be influential in nursing. That I guess is important to me. I like to be a driver in improved healthcare for Canadians. So if my role puts me in an influential position that way, and somehow it doesn't feel like we actually get to talk to people who are of influence, are actually making decisions. (P03, lines 497 - 501 first interview)

Participant 03 expressed agency in their narrative. Like other participant's comments in Section 5.1, Participant 03 conveyed tension in wanting to be prominent in forums to make changes but conveyed that they were not given opportunities to be influential. Other participants disclosed that the government and insurance companies did not facilitate independent practice, setting up barriers to practice.

In this section, participants described the challenges they experienced when hearing some conventional discourses about nursing and nurses. They often felt exposed to misinterpretations about NEs in homecare. They revealed circulating knowledge and non-knowledge about homecare nurses among the general public, the government, and healthcare providers, which extended to themselves as NEs. These perceptions created tensions for participants between their nurse and executive identity. It also created challenges when trying to advance their professional agendas.

5.3. Managing the Flow of Information

In this study, participants disclosed how sharing nursing, patient care, and homecare information within the HCO was critical to their ability to function effectively as an NE. They reflected on how information within the HCO flowed up to their CEO or President of the Board of Directors, laterally with other executives, and downward to other staff and the nurses working at the point of care. Participants also expressed concerns about sharing information external to the HCO, which I will discuss in section 5.4.2 when I address their strategic alliances.

Participants' narratives revealed their multi-positionality as objects and subjects of power through their daily management of knowledge flows, interruptions, and obstructions. As objects of power, participants described that the traditions and norms in the HCO shaped them to act in

specific ways. However, as subjects of power, they also controlled information by acting at their discretion.

Three sub-themes emerged from participants' interviews. The first theme exposes participants' experiences when demonstrating the relevance of nursing, patient care, and homecare within the HCO. Participants discussed the dominant discourses within the HCOs and how this impacted their ability to manage the flow of nursing information. The second theme reveals participants' involvement in discussions and their influence on decision-making in the HCO. Many participants called this "having a seat at the table." Specifically, participants revealed their challenges in accessing and providing information they deemed necessary. In the final theme, participants highlighted how they had to manipulate information and manage expectations within the HCOs to meet their agendas.

5.3.1. Demonstrating the Relevance of Nursing

In this section, I discuss how participants demonstrated the relevance of nursing in HCOs. This included imparting their nursing knowledge to the executive team, CEO or President, staff reporting, and the nurses delivering homecare services. This entailed a particular understanding of nursing and management. It was a priority for participants to position their knowledge strategically in their roles as NEs. Most participants positioned nursing knowledge ahead of management knowledge. For example, Participant 06 stated:

> There are two streams of thought. One stream will say just know management. Just understand what management is. Understand the practice of management, and you'll be fine. Doesn't matter what sector or what industry. If you [understand] management, you've got it [*groans*]. … but if you are in healthcare, understand nursing, understand if you are a nurse in health care, understand nursing, understand why we exist and what the

> client-patient-nurse relationship should be. You're supposed to be from a department perspective, from an ethical perspective. [*pause*] From a caring perspective. That is the core set of knowledge, … for every nurse seeking a management career. (P06, lines 369 – 376 first interview)

Participant 06 presented a discourse of two streams of thought that positioned management and nursing knowledge as different knowledge sets. In speaking about a successful career, the participant suggested that solely understanding management was problematic. Instead, the participant positioned themselves in the second stream of thought. They normalized that positioning when speaking about every nurse seeking a management career needing nursing knowledge to be a good NE. Participant 06 identified management knowledge as secondary and more straightforward to acquire. We can see the contrast between the quotes from Participant 06 and Participant 13, whereby Participant 13 positioned themself in the first stream of thought. These different points of view highlight the tensions among participants. Participants understood that different strategies are coming from these two streams of thought that impact how and why they demonstrate the relevance of nursing.

All participants conveyed that they were the source of nursing knowledge at the executive level of HCOs. This idea was perpetuated by nursing associations, such as ICN, CNA, and RNAO, that published and offered nursing leadership documents and courses. Many participants were members of at least one of those nursing associations. For example, RNAO described this role as a governance responsibility in their framework: "Identify and communicate the link between nursing work environments and nurse, client, and organizational outcomes to the Board/Senior Management Team" (D5, p.4).

Other leadership organizations also sustained the discourse that NEs were to communicate and share their nursing knowledge. Of the eight participants with certification in leadership or management, four had Certified Health Executive (CHE) Program credentials. The CHE credentials in healthcare leadership were from an organization that offers a global program for leaders across disciplines, such as medicine and nursing. The CHE Program was based on: "The LEADS in a Caring Environment capabilities framework [which] defines high-quality, modern health leadership" (D7, p.4). Two scholars with combined education, economics, and health policy backgrounds developed the text. The CHE Program is strongly endorsed by healthcare organizations, nurse leaders across health sectors, and nursing associations globally. The LEADS framework addresses communication in four of its capabilities for a leader:

> "**Set direction** - They inspire vision by identifying, establishing, and communicating clear and meaningful expectations and outcomes.
>
> **Communicate effectively** - They listen well and encourage open exchange of information and ideas using appropriate communication media.
>
> **Strategically align decisions with vision, values, and evidence** - They integrate organizational missions, values and reliable, valid evidence to make decisions.
>
> **Mobilize knowledge** - They employ methods to gather intelligence, encourage open exchange of information, and use quality evidence to influence action across the system." (D7, p.3).

We see an example of Fairclough's intertextuality, representing how distant texts and discourses import local effects. As such, those interdiscursive arrangements had meaning for participants and influenced how they envisioned and implemented their roles as NEs. Authoritative,

internationally recognized organizations disseminated these discourses, which helped NEs build their organizational and executive credibility.

Such discourses influenced how participants thought about their role as NE and their responsibility to demonstrate the relevance of nursing. The program suggests that NEs, as executives, can put forth a convincing discourse, such as demonstrating the relevance of nursing, using the program's tools. We then see interdependence and, as such, the CHE Program works as a critical epistemic device, creating discourses about executives as carers and being resilient. It is important to note that other similar leadership programs and guidance documents work similarly, echoing many of the discourses put forth by the CHE Program. For instance, a dominant discourse of health executives being effective communicators is often positioned as needed to meet organizational goals (ACN, 2015; American Organization for Nursing Leadership, 2015; CNA, 2009; RNAO, 2011).

Participants worked to make their nursing knowledge evident through their narratives. They often stated how important it was to bring their nursing, patient care, and homecare knowledge into the corporate discussions to influence operational and clinical decisions at the executive level. This was important to participants to be seen as credible knowers by the other executives:

> I have the financials and there are limitations to what you can work with, … even though you're in there to do that dressing, you don't have all day to be in there to address everything. But I think that a lot of work can be done within that visit. And the other piece is if you're a nurse, as you know, you're going back to see Mr. Jones three times that week, not everything has to be done in that one visit. And that's the beauty of going three times a week. So you just don't address the wound because there's a whole lot of other

> issues going on in that family that needs to be addressed. Because the wound could be on his arm, that got cut off, and he works as a machinist. And now he doesn't have a job. So the wound is but like one tiny little piece of what you're trying to deal with, a family that's in mourning over the primary financial provider in the household not being able to work and, on and on it goes. But then that's where it's on us to ensure that we're giving nurses back the accountability to be determining who they're seeing when they're seeing them and managing their caseload versus just sending them all around. (P08, lines 260 – 274)

Participants emphasized that the relevance of timely and quality nursing, homecare, and patient care must be understood by the other executives in the HCO. Without a common understanding of this knowledge among the executives, participants explained that financial and human resources were ineffective, and people would not receive the required care. Nursing human and operational costs to the HCO and the healthcare system exacerbated participants' arguments to create a different understanding of homecare nursing: "What are the clinical outcomes? I know that I have fiduciary responsibilities, obviously, to keep things within budget, but let's make sure that we have value within that" (P01, lines 175 - 177).

One participant exemplified the complexity of the organizational structure in the HCO and its impact on their ability to demonstrate the relevance of nursing. They noted their intricate and multifaceted responsibilities: "I touch everything in the organization. Patient safety. … nursing and personal support. But what that entails, the quality, the safety, the risk, the infection control, the documentation, people don't understand how complex it really is" (P10, lines 313 – 318). While this quote exemplified the need to share information, the participant justified

knowledge retention due to the complexity of the environment. The participant demonstrated considerable power and influence in their role as NE.

Keeping records of discussions and strategic decisions and disseminating them within the HCO was an approach that some participants used to capture organizational knowledge and establish accountability. This practice was, however, not always a norm:

> I always believed that the briefing note, the report, the written tool, was the most powerful way to articulate what it was you were trying to do. And to share that, to get other people to see that vision or that need. That's what I learned, is that in that environment, they hated paper, they didn't want paper. … it was a bit of shock to me because I thought in senior management, everything was thoughtful, carefully debated, matched with strategy. And that isn't what I found. (P06, lines 307 – 317 first interview)

By putting things in writing, this participant was enacting their agency. They were actively working to capture the knowledge circulating in the HCO. This participant notes that this was the business practice they expected to ensure corporate memory. Knowledge would be transparent if records of what was transpiring within the organization were kept.

Participants felt they needed to know nursing and its relation to organizational finances for several reasons. As discussed in section 5.1, maintaining a high-functioning nursing workforce was challenging in homecare. Promoting the independence, creativity, and autonomy of staff nurses in the HCO and having other executives understand this rationale about retaining nursing staff was necessary:

> The group that carries the highest risk [of not being understood and being under valued] is certainly the nursing group. So this is where it's really important to have a very strong professional practice, vision, and focus, to make sure that you're supporting your nursing

> team to be the best that they can be. Right? And of course, it's not as easy in homecare, and you would know, [not as easy] as it is in institution-based healthcare as a whole, whether it's a hospital or a group home or a long-term care facility. When our nurses are out in the field, they are by themselves, and they are problem-solving in the moment, managing complex medications and procedures, probably also providing psychological and social support to the families, and the siblings, and the parents, and the spouses of the people they're looking after. (P07, lines 27 – 35)

Being able to convey to the staff nurses that nursing services could be delivered despite resource constraints was also important to participants.

> The CNEs[15] role is to make sure not only are you [the NE] putting in best practices and best practice supports, but they [the staff nurses] actually work for people who are doing this kind of role. (P07, lines 42 – 44)

We see an example of Fairclough's intertextuality when the words 'best practice' are incorporated into P07's statement without attribution to the source. Toward the end of the interview, Participant 07 conveyed how they enacted their nurse and executive identity:

> I think to hold a CNE [Chief Nurse Executive] position you also have to be quite happy to be the voice of one. You need to be quite strong I think in your knowledge. You need to

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[15] While participants used titles such as Chief Nurse Executive (CNE), as noted in Chapter 1, I am using NE to describe the various titles of nurses in those executive positions.

> be able to speak up eloquently. You need to be able to bring things forward from an evidence-based approach. And you need to be willing to fight for great quality and great practice and make a really solid business case for it. Because I think it's very easy for a cost saving exercise, to shave off practice pieces, before they start to shave off other things. And so I think you have to be able to create a powerful business case, and then be able to present it eloquently and consistent and concisely, and stand behind it, and have good metrics, and be quite professional about it. I think that's really, really important. (P07, lines 261 – 269)

Here, the participant strategically combined nursing and administrative knowledge to be influential. The knowledge participants mobilized to the staff nurses differed from what they conveyed to the executives within the HCO. Many participants had previously worked as staff nurses in HCOs. They understood that staff nurses were interested in their ability to do their job correctly by providing the best experiences to individuals and families.

Participants knew that it was rare for staff nurses to be concerned with the daily fiscal requirements of the HCO. The knowledge participants acquired as homecare staff nurses allowed them to be seen as credible knowers of homecare nursing by those nurses working for the HCO. However, participants were working against the dominant discourses circulating within the HCO, the fiscal management of resources. Participants noted that the knowledge that influenced decisions at the executive level in the HCO was about something other than the clinical aspects of nursing and its impact on quality patient homecare.

As discussed in section 5.1, participants knew there were limitations within the HCO's budget that impacted the delivery of nursing services. The discourse of resource utilization and budgetary requirements was prevalent within the HCOs. In addition, profitability and cost-

cutting measures were other dominant discourses that drove the discourse of sustainability of HCOs. Understanding those discourses circulating in the HCO was significant for participants to demonstrate the relevance of nursing strategically. Participants seemed to accept the rhetoric of aligning nursing, profitability, and productivity within the HCOs' organizational goals: "I learned a lot about cost-benefit analysis and how to do that work … the tripod of finance, admin, and clinical. I think over the years I learned a lot about how to keep that stool steady" (P04, lines 342 – 344 first interview). This participant suggested a connection between the nursing aspect of the HCO and the administrative and financial oversight, underscoring the tenuous balance of managing those three responsibilities and types of knowledge.

The discourse perpetuated by the previously discussed CHE leadership program reinforced the balance of these interdiscursive elements: "Clinical skills won't suffice when you become a manager and to move up to CEO you must develop many new capabilities" (D5, p.63).

Having administrative, financial, and nursing knowledge was independent of whether participants were the CEO of the HCO or not. Instead, most participants expressed being convincing in conveying their arguments to meet their agenda. Their positions as NEs within the HCO impacted how they demonstrated the relevance of nursing. This was dependent on with whom they were interacting. Participants recognized that the other HCO executives had knowledge from different educational backgrounds that they used and saw as relevant to the organization's functioning. Grounded in varied areas such as business, financial, human resources, law, or technical knowledge, these were based on the executive's education and position within the HCO:

> People [other HCO executives] are there because of their skill set [i.e., administrative, legal, technological], but they don't understand nursing, and they don't understand

> homecare. And they probably have never been to visit a patient, so they have no idea. … They understand the business from their perspective. (P12, lines 672 – 676)

Participants expressed a position of knowing what knowledge other executives had. In the above quote, we see Participant P12 situating themselves in a powerful position by suggesting that it is problematic that other executives are interfering with participants' skill sets and knowledge. This was significant as it allowed participants to address the other executives' knowledge and ignorance strategically. They demonstrated the relevance of nursing based on what they thought the other executives needed to know or not.

Participants would capitalize on that by strategically connecting their nursing knowledge with the pieces of knowledge that participants thought the executives already had about nursing to move their objectives forward. However, many participants disclosed frustration linked to their unsuccessful attempts to educate the other executives about the relevance of nursing. In participants' views, nursing and patient care remained unseen as critical elements of homecare despite these educational efforts: "They [the other executives in the HCO] had this really restrictive thinking about what that [nursing] might mean, and how it could help the organization. And they just couldn't reconcile that at all" (P04, lines 153 – 155 second interview).

Participants were challenged with the power dynamics within the HCO that often interrupted or blocked the flow of nursing knowledge. Despite demonstrating the relevance of nursing to the other executives by aligning it with the dominant discourse within the HCO, participants expressed that the other executives only sometimes saw nursing and patient care knowledge as relevant. Participants expressed tension that was exacerbated when they forced nursing knowledge into corporate decision-making:

> And so it was, once again, the tug of war, I can't tell you how many presentations I made [to the other executives] to talk about … identifying what best practices are for wound care. And you're not delivering those best practices, how can we expect the patients are getting quality care? Because somebody else decides they know better? So it was, it was always this constant tug of war. (P04, lines 86 – 91 first interview)

Absent from participants' narratives were indications of when and under what circumstances nursing and patient care knowledge were deemed relevant. However, what is noticeable in the above quote by Participant P04 is that there is selective uptake of certain kinds of knowledge by the other executives.

How participants managed these challenges will be discussed in the following sections. Participants conveyed their enactment of agency when demonstrating the relevance of nursing, patient care, and homecare within the HCO. They exposed this in how they imparted specific knowledge based on whom they were speaking with to meet their agendas. They also expressed tensions between their identity as a nurse and executive in those endeavours.

5.3.2. Having a Seat at the Table

In this theme, participants revealed how they accessed information and what forums were available to share their knowledge and demonstrate the relevance of nursing in the HCO. Many of their narratives included the metaphor 'having a seat at the table' to describe what they expected of their involvement in discussions and influence in decision-making. In the participants' views, all executives in the HCO would have the same opportunities to speak, be heard, be influential, and contribute to decision-making.

Participants used this metaphor to represent the bringing together of ideas, a continuous sharing of information, where each executive was engaged and able to manage the flow of

information in the HCO: “I would say it [the influence of NEs] has to do a lot with having a seat at the table. But not just the chair. That's irrelevant if you don't really play the role” (P05, lines 242 – 244). This participant’s vocabulary suggested a need to conform to a perceived executive role. The phrase “play the role,” similar to “play the game,” which was discussed earlier from Participant 12 in section 5.2.1, implies that their success hinges on doing things in an acceptable way established by the norms and traditions of the HCO, which are highly political and methodical. However, all executives being equal executive team members was a theoretical expectation that created a naïve, apolitical understanding of how information flowed in the HCO. Nevertheless, it was understandable that participants expected this level of engagement at the executive level.

The metaphor “having a seat at the table,” also perpetuated by many nursing organizations, while not always stated verbatim, was implied by many participants. The metaphor reinforced the discourse of HCO executives sitting with equal positions around a table, having the same agenda, and working towards common goals. For example, CNA invokes the image of a table, a physical structure, which positions the NE as authoritative: “To create vibrant, safe and innovative practice settings, nurse executives in all organizations that deliver health care must sit at senior decision-making tables and be delegating the authority and resources to implement high-quality care practices” (D4, p.2). This statement from Document 4 assumes that healthcare organizations create collaborative executive meetings as forums that promote equal authority and decision-making power. The language in this document presents a unifying executive structure.

In reading Document 4, participants could interpret that the obligation to “create vibrant, safe and innovative practice settings” was theirs, while sitting at the table with the other

executives. As I discussed in earlier sections, for many participants, one of their critical responsibilities was to ensure the delivery of safe, quality patient homecare. However, individual participants did not describe executive meetings as collaborative, nor did the HCO executives describe them as a homogeneous group.

Document 5, a leadership framework for NEs from RNAO, also identifies "the table" as an expected mode of operation in healthcare organizations. Within this document, RNAO positions governance and leadership roles and responsibilities for NEs within an executive table: "The following framework is intended to illustrate Chief Nursing Executive [CNE] and Chief Nursing Officer roles and responsibilities in the context of membership and participation at the senior management and Board table" (D5, p.1). A discursive pattern emerged from these and the following document.

As a visual representation of group meetings, the table implies that this is the singular mode for executive decision-making and influence. Document 8 takes this concept further by addressing collaboration among executives in healthcare. This document proposes an alternative to a hierarchal leadership system: "Rather than a more hierarchal system of leadership, collaborative leadership assumes that everyone involved has unique contributions to make and that constructive dialogue and joint resources are needed to achieve ongoing goals" D8, p.278).

The document suggests that constructive dialogue can occur without system or organizational changes. It promotes collaborative leadership in healthcare organizations that is inclusive of everyone, overlooking the reality that many healthcare organizations, such as HCOs, function hierarchically. This document does not provide participants with the tools to manage systems where "a more hierarchical system of leadership" still exists. There is a convergence

between such a document and what is sought. For example, one participant stated that the homecare system required a change in how information was shared, and decisions were made:

> The system unfortunately, has set us up for conflict. And it's like, so ordinarily you would sit down and have just a great conversation and problem-solve something. But because … the system's outmoded … it inflames conflict. It promotes rhetoric, I think, around bureaucracy. (P01, lines 335 - 344)

This participant uses the table metaphor, establishing that same imagery of sitting down collaboratively to converse. However, Participant 01 also reflected that being influential and sharing information is more complex than having a conversation. The specific phrases used by the participant to describe the homecare system as “outmoded” and how “the table” can facilitate conflict are powerful. Participant 01 implied that the traditional HCO organizational structures, of competition among the various HCOs and the different executives within HCOs are problematic. Participant 01 addressed the infrastructure changes, mentioned in section 5.1, as problematic concerning their influence:

> I think that's a complex, certainly the, the system is complex, because you want everyone that's delivering care to patients to be engaged and motivated and thinking about their experience. But that's very hard in the current system that we have because there's so much fragmentation and so it's very arm's length. … looking at how to work together, particularly during this time of change when the system is at risk of becoming very destabilized. (P01, lines 195 - 199)

Concerns with the reorganization by the Ontario government to reduce the number of Home and Community Care Support Services was troubling to this participant. Rather than NEs being able

to focus on homecare delivery, attention within the HCOs was directed toward changes in funding models and reporting mechanisms. This participant noted that this compromised their having an equal voice compared to the other executives.

Participants also reflected on what was happening around the executive table in meetings. The focus was often on what was on the meeting agenda, which drove those executive discussions. This often meant that what was not on the agenda was not discussed and dismissed or disregarded. Participants did not mention who developed the meeting agendas and whether everyone agreed on the items presented.

Participants expressed their expectation to have an equal voice with other HCO executives. In this context, participants discussed the issue of being a female in the HCO environment, as they previously raised in section 5.2 .1. Participant 03 felt that it was necessary to change how they presented themselves in these meetings:

> Researcher: So do you act differently when you're around these tables?
>
> P03 … Oh Yeah …
>
> Researcher: How do you position yourself here?
>
> P03: Yeah, I try to prepare myself psychologically for these meetings, because I've been in them a few, … and often the challenging part is that I'm always, I'm almost always the only woman in the room. So that's different. And then I sometimes feel like I'm spoken over, disregarded. A little bit of gaslighting even, just like, I say, No, no, that's not what we agreed. It's like, no, no. Yeah, it is. … But I do feel like I've been in so many meetings where I'm the only woman. And I feel like the energy of meetings are different also when they're led by men and there's only one woman. It's just a different kind of meeting, I find

> that the way the meetings' conducted, allowing people their fair share of time to answer or to give input, rather than just charging on through, it's a different, it's different dynamics, for sure. (P03, lines 181 - 194 second interview)

Participant 03 describes a paternalistic management structure, where the male executives control the meeting, which places them in a powerless position. By manipulating what the participant said in meetings, other executives minimize their authority and potentially create self-doubt in the participant's mind. This may or may not have been intentional, but it is important since it positions this NE's role, status and their knowledge as irrelevant. In order to have a seat at the table, Participant 13 explained that varying knowledge among the HCO executives was needed:

> So around the C [executive] table, you have to bring in the skills that you need for your strategic planning, your financial planning, your HR [human resource] planning, so if anything, like we used to say, I think, separate out, I'm a nursing exec [executive], we don't do that anymore. I'm an executive, … my background happens to be nursing. But I happen to use my nursing most of the time, but I use my [business knowledge] a lot more [laughing] in terms of financial and HR, etc. Labor Relations. Um, so I think … it's [focusing on nursing] detrimental to us. You know, an executive is an executive. (P13, lines 355 – 361)

This participant noted that to be effective, the breadth of knowledge they required as an NE was broader than nursing. They strategically position their executive identity and knowledge at the forefront to be visible. They state that without a broader knowledge base, it is detrimental to their influence. There is also an implication that they may not be accepted and heard. The participant does not mention whether the other individual executives require a similar varied knowledge base other than the specific field of knowledge that they have, such as finance or human

resources. Yet they state that “an executive is an executive.” This sets up an impression of different expectations for the HCO executives, setting specific rules for the NE.

As discussed in the previous section, participants suggest that the dominant discourses in the HCO focused on fiscal management of delivering homecare services to patient. Participants indicated that this impacted the influence that they had with other executives. While Participant 13, above, positioned their executive identity at the forefront, Participant 08 recognized their executive identity. However, Participant 08 positioned their nursing identity at the forefront:

> I'm looking at things through a nursing lens, but I'm accountable for representing a broader sector. … and having the goals and objectives and accountabilities of the organization, not just for nursing, but for the entire organization. So while I may view it through that [nursing] lens, I'm not always there acting only on behalf of nursing, because I think that would be very limiting for the organization and for nurses, actually. (P08, lines 138 – 142)

Both participants contended that their executive and nursing knowledge dictate how they present themselves to other executives. However, they also express a conflict in their identity as they move between their executive and nurse identity, trying to justify their role at the executive table. It was important for other executives to recognize them as an executive who were knowledgeable and well-informed in both domains:

> To have a seat at the table, other participants aligned their values with those of the HCO: I have my own personal experiences, values etc. But luckily enough, they are intertwined with the organization's values. The experiences I bring is added value in the organization. (P09, lines 238 – 239)

This participant saw it as advantageous that their values intertwine with those of the HCO. This helped to relieve any tension between their two identities. They proposed that it is coincidental that the two sets of values aligned, suggesting vulnerability if they did not. Participant 09 also positioned this within the value they brought to the HCO:

> But, again, part of the value that I, my role has is, I need to understand service. I need to understand what happens at the pointy end of the needle. And I only do that by going out and seeing it. Right, I do that by talking to those that do the work. I only do that by creating forums for people to talk about practice. So the value of the role is understanding what happens at the pointy end of the needle. Both good and not so good. (P09, lines 300 – 304)

Observing what the staff nurses were experiencing, the participant could justify their seat at the table. They felt that this gave them credibility with the other executives.

Participant 01 expressed a different perception of the acceptance and positionality of the NE at the executive level. They reflected on being grounded within the context of the organization, the nursing community, and the broader healthcare system, often feeling instrumentalized:

> Researcher: Tell me a bit about that instrument feeling … Or even if you have an example of something that would help me understand it.
>
> P01: Um, so again, I think it comes down to kind of sort of directives, “you will make this change happen, this is a change that's bigger than you. And so you need to do this, and you need to do this well.” And so, I feel like, then, those times I'm being instrumentalized, by the system by the state by the government, and it's sometimes in

> conflict with my beliefs as well. And so, if there's a certain budgetary thing as well, that, whether it's a restricted budget or not getting as much budget as promised, then it's how do I implement this? and cause the least amount of harm? (P01, lines 285 - 294)

In talking about being instrumentalized, Participant 01 projected that they were deprived of their agency and compelled to manage selective tasks. However, they conveyed agency in their narrative when reflecting that they looked for opportunities to manage those situations. This connotes an image of the participant being used as an object that must conform to and accomplish the goals of the government and the healthcare system. The application of their role as NE is covertly challenged, wherein their showing the relevance of nursing might lead to their instrumentalization. This situation set up a power differential that placed the participant in a subordinate position, minimizing their knowledge.

Other participants did not use the term “instrumentalized” but did describe situations where they focused on tasks. Participant 12 described using strategies to shift discussions within the HCOs that moved them away from being instrumentalized:

> First of all, you have to learn all about the budget so that you can talk about them [the budget]. And they're right, they're very complex. You also learned how to present your case really strongly and not get upset when people did something else. But it was, I would say it was the ability to sit at a board table. … So everybody's defending their territory. And that was the other thing that was interesting is that there's collegiality. But when it comes down to it, you're defending your own program. So I had to learn that it's not everybody in this together. It's everybody for themselves, basically, although they would never say that. So that was an interesting learning. But nursing in no way prepares you to sit at those tables at all. … You need to learn that executive stuff, but that you can

> learn, it's more of how to be at those tables. And speak up and say your opinion and know how to move around those tables? And I'm not sure how you learn that other than through experience? (P12, lines 205 – 230)

Throughout the two quotes above, Participant 12 proposed a conflicting executive environment that implies being protective while also being friendly and uncompetitive. They described sitting at the board table as a learned skill set most likely acquired through experience. However, as Participant 12 suggested, these experiences were fraught with tension, which was not conducive to learning. This created a potentially untenable situation. Both participants related their endowment with different expectations, sometimes reconcilable and sometimes not.

Participants explained that they had disparate opportunities compared to the other executives in the HCO to discuss their portfolios or to make decisions at the executive level. That limited participants' authority and credibility, as described by the following participant, who contended with the organizational hierarchy that existed in the HCO at the executive level:

> Everybody knew what a CNE [Chief Nurse Executive] and a CNO [Chief Nursing Officer were. … And inside, it was very challenging to convince people in this line position how I was going to interface and work with them and really explain the breadth and depth of the job. … If I hadn't been a nurse, if I had just been an MBA [master's in business administration], I think it would have been different when I was talking about why we needed things, I talked to them [other executives] about the patient level, the staff level, and that was a part of my nursing practice, bringing all of those issues forward. (P04, lines 165 – 181 second interview)

Participant 04's nursing identity created challenges, as they were expected to explain the breadth and depth of their knowledge to other executives. The participant continued to endeavour to

impose nursing knowledge into operational decisions, trying to shift what they felt was essential to know and consider by the executive team. However, later in the interview, Participant 04 described how the fiscal goals of the HCO did not match the organization's clinical needs, which stymied their efforts: "The problem is that you [the NE] are not budgeting correctly [in the view of the executive responsible for operations] for how [you] need to deliver quality care. That's the problem" (P04, lines 188 – 190 second interview). The participant presents a scenario of not conforming to budgetary decisions suggested by other executives. This created conflict for the participant.

Other participants' narratives described situations that confronted the assumption that all the conversations and decisions occurred during executive meetings. Participants discussed conversations that occurred outside of executive meetings as a way to manage the flow of information in the HCO. They contended that nursing content was only sometimes on the agenda in those meetings. Consequently, participants noted that other means were necessary to attract attention to items that they deemed important. They recognized that many of the decisions in the HCO were often made outside of those meetings and discussions at those tables.

Participants discussed their relationships with their CEOs. These relationships were described as mostly positive. Participants described the CEO of the HCO as being in a position of power with authoritative legitimacy to make final decisions about all clinical and operational matters. Consequently, participants stated that it was important to have the CEO's ear. This required significant participant resourcefulness and a supportive Chief Executive Officer or President. Many participants contended that having a supportive CEO who understood the connection between clinical and operational outcomes was important. Participants described CEOs who were RNs as being more open to having discussions about nursing and patient care.

Participants described accessing their CEO as a means to have a voice and be influential. One participant explained that they had excellent access to their CEO:

> Researcher: Do you have good access to your CEO?
>
> P10: I have very excellent access. Yeah, yeah.
>
> Researcher: What does that look like?
>
> P10: I have meeting[s] with [my CEO] ... Yeah, very accessible. (P10, lines 122 – 126)

While this participant noted having regular meetings with their CEO, whether those meetings were effective or not was unclear. Throughout the interview, they maintained a positive discourse about their CEO and position as NE.

Other participants struggled in their attempts to be seen as credible. Participants reflected on strategizing when making decisions. They shared how they were absorbed in the language, modelling, and discourses that gave credence to profitability and the strategies needed to realize profit while demonstrating the need for clinical services. While participants noted that they viewed themselves as part of that endeavour and accepted certain institutional limits, they made choices to advance their agendas. One participant articulated the effort and multiple responsibilities required to demonstrate the value of nursing in homecare:

> In addition to my primary vision ensuring safe, quality ethical care in the organization for patients, and ensuring staff had the tools, resources, and support to do their best work and patients had the best experience and care outcomes, there were some other important functions that I integrated into my role. 1. Breaking down silos across organizations in the home and community care context; 2. Elevating the voice of homecare and nursing in

> homecare at decision-making tables outside the organization; 3. Contributing to the body of knowledge of homecare and homecare nursing. (P04, first email)

For this participant, having a seat at the table also meant having visibility and influence outside the HCO. The participant showed their nursing and executive agency in this quote. As reflected in the following quote, other participants described situations where they encountered censorship: “Because at one point, I was told I was far too strong a personality to be a nursing manager. I’m like, wow, that’s interesting. And why would that be? Because I spoke my mind” (P11, lines 505 - 507).

The assumption that NEs should not be assertive is observed in this participant’s quote. They reflected on past experiences where they experienced censorship from other executives. This created discord in terms of their organizational relationships. By confronting censorship, the participant’s nursing identity was strengthened. They confronted this suppression and exerted their agency. Another participant also contended with being censored:

> I have to be careful in what I say and how I say it. … So politically astute is how I respond to things. And I've learned that over the years, I've learned you have to learn that. … you [have] to be able to go with the flow. You have to be able to expect curveballs. (P02, lines 423 - 440)

This participant managed how they interacted with other healthcare professionals by being politically astute. They described being politically astute as accepting situations and coping with whatever comes their way. They worked within the conflict to meet their goals. Having an equal voice with other executives in the HCO often required participants to conform, compromise, and resist. Participants described the NE role as influential within the HCO and externally with the government. They felt they were equipped to take on opportunities to make changes in

legislation involving an advocacy role. However, they were not always offered those opportunities. In the following quote, the participant notes influencing decisions indirectly:

> The senior management team plays with government relations, right? So being able to feed up some of the key messages through the various tables, perhaps not me directly, but the CEO at their table. So it's about influencing without having a lot of control. (P09, lines 196 – 199)

This participant revealed a strategic method to be influential by engaging in dialogue with their CEO to advance their agenda as an alternative to executive meetings.

In this section, we saw how participants explored what having a seat at the table meant to them, reflecting on challenges that created conflict. They presented scenarios where they felt included in forums for decision-making. However, they also noted that they were only sometimes heard. They assumed that their position as NE included involvement in all conversations and decisions. Participants chose in which dialogues to engage. They disclosed strategies to include themselves in influential discussions in a group environment or with one individual, usually their CEO.

5.3.3. Managing Expectations

Participants described strategies they used to manage expectations, responses, and conversations. This idiom was about participants not always following the norms and traditions in the HCOs to advance their agendas. Participants worked around usual and accepted corporate practices within the HCO. Participants revealed they were aware of organizational limits but chose to go along only sometimes with practices, rules, and conventions. One participant understood that they needed to elevate nursing discourse within the HCO rather than having it seen as a support function:

> Another challenge was the constant competing priority with operations for budget dollars and growing the bottom line. My work and that of my team was seen as "support" not imperative to overall operations so it was easy to cut important initiatives and sometimes important headcount creating more pressure and challenges to achieving our goals. A critical skill was the ability to stay motivated, committed, energetic and to become increasingly more innovative to achieve the goals we set for ourselves. (P04, first email)

Here the participant reflected on the dominant discourse circulating in the HCO: profitability and clinical responsibilities. This created tension for the participant. This prompted situations whereby the participant felt it necessary to redirect discussions to make what they deemed appropriate decisions:

> Finding your own voice and confidence in speaking out was another important skill set that I developed. Not something that is taught in nursing school. … The priority should always focus on what people/patients need and doing that well. The system and some working in it did not hold the same inclusivity and diversity values that I had but with persistence and continued collaboration efforts and when others saw the value add I could bring to decision making it was easier to get seats at those decision-making tables. (P04, first email)

The participant struggled with the tension of trying to enact daily transactions and negotiations. Other participants managed confrontational discussions by taking accountability for their decisions. One participant described those discussions as only sometimes being about negotiation.

> If you work with a good colleague, they'll stop and ask those questions, and they'll consult with you. But at the end of the day, they are consulting with you. And to make them understand that sometimes it isn't a consultation, this is how it needs to be. So you can't take this and adapt it and adjust it and work it out whatever way works best for you. This is a standard. This is risk mitigation. This is about quality, what's best for the patient. (P08, lines 384 – 390)

The participant evokes agency by inserting nursing knowledge into the HCO. They aligned this with their nursing identity, as noted when they said what is best for the patient. This participant describe a good colleague as another executive who engaged with them. Here the participant had visibility and imparted their knowledge.

Participants described their work environment as demanding and complex. This challenged one participant to assess and consider alternative solutions critically. They exemplified their autonomy and influence by describing incidents with their CEOs and other executives in the HCOs. They described how it was natural and expected for others to pull them in different directions:

> I'm so busy, that I don't have time to step back and just kind of look at things as critically as I might like, because sometimes the pace is always so fast that sometimes that critical reflection doesn't get done in as much depth as it should. (P10, lines 270 – 273)

This participant says that she cannot take a step back from the magnitude of their workload to function. Another participant expanded on this by describing situations where they acted strategically:

> Well, I think, again, it's keeping an open mind for the potential and, and timing is always critical, right, in terms of when you deliver what message when. Because again, when you're running into issues around health, human resources, because various sectors upstream may have changed their model of service delivery. (P09, lines 172 – 175)

Deciding when to make decisions and visibly expose their knowledge or not was exemplified by this participant. However, some participants expressed the need to balance their expectations with the organization's. One participant discussed the control they required in managing negotiations:

> It never necessarily goes the way you want. Because you're constantly wanting to negotiate where something is a priority for you. And you think that that should be the organizational priority, but you also have to balance with fiscal responsibility and context. And again, I'll just underscore in a contract environment, there's always a push pull that has to happen because you can't do everything that you want to do in any department without some negotiation across. So I think that there's always an opportunity to shape and influence. And even if you don't get the changes in your direction, you still had the opportunity and you feel heard that this is important, but perhaps not priority 1A and 1B, maybe it's priority 2C? (P09, lines 147 – 155)

One participant explained that the rules of the HCO were binding: "You are bound by the rules… There are so many equal priorities and needs that there is nowhere to go – it is not sustainable". (P16) (Lines 77 – 78). Stating that the rules of the HCO were binding them demonstrated the difficulty that the participant had in deviating from the set agenda and outcomes in the HCO. Noting that was not sustainable exposed the constraints and struggles the participant experienced

to work in ways that made their job easier. One participant framed meeting their goals by positioning them within nursing ethics:

> Nurses have a strong code of ethics. And so it's always about going back to that code of ethics, nursing code of ethics, about doing no harm, no intentional harm, equity, and really trying to refocus that within an ethical lens. … I don't know that I always do that consciously. But I do think, again, that nursing gives you a very solid grounding in framing things within an ethical lens. (P01, lines 310 - 314)

Trying to refocus within an ethical lens heightened this participant's nursing identity. We see a purposeful strategy to maintain control of the nursing discourse within the HCO.

Participants exposed the difficulties of working within a system that would stay the same. They expressed feelings of exhaustion and resignation. They described these situations as impacting their physical and mental health. The following participant exposed the emotional harm they experienced:

> Well, we would try to [bend the rules], we tried to be involved and to steer the boat as much as we could. … It was this constant balance of how much can we steer, still sleep, and not have our guts chewed out for unethical things, without getting shut out. So I would say, when we talk about bending the rules, I, we would do what we had to do, for the benefit of the patient. (P04, lines 326 – 331 first interview)

This participant suggested feeling uninfluential. They used metaphors such as "steer the boat" and "not have our guts chewed out," implying the need to be in control.

While not all participants described their actions as working around the norms of the HCO, their narratives conveyed that they were managing expectations of themselves and other

executives. They developed strategies such as relying on the nursing code of ethics to maneuver around the conventional processes in the HCOs. Participants sometimes compromised to meet their agendas. One participant described this within the scope of merging the needs of people requiring care with those of the HCO, as we heard previously from Participant 04:

> Researcher: So have you found yourself in situations where you've had to compromise in situations like that?
>
> P07: [Nodding] Yes, but I don't think I've had to do it any more than another member of the senior team. I think it's just organizational. It's just coming up things from an organizational perspective. So when you're trying to say I would like another half an FTE this area. And your CFO needs another half an FTE, because they can't manage payroll. It's in your best interest from an organizational perspective. And if you think about clients or families then you both get some support to be able to be successful. (P07, lines 270 – 278)

This participant explained that they were in a similar position to other executives in the HCO. They were all attempting to meet their goals. They framed this within the traditions of the organization. It is interesting to note that the participant stated it is just organizational. This demonstrated that these were acceptable norms. Participants suggested they had to do more than cooperate with other executives to move their agenda forward. They contend that the HCO's culture required them to maneuver their agenda strategically.

Participants also expressed the need to collaborate with other executives in HCOs. They discussed the limitations of working independently without consultation. One participant found it necessary to cooperate with the other executives: "But a CNE [Chief Nurse Executive] working alone - you just can't get anything done. No, you're just ineffective" (P07, lines 301 – 302). Later,

this participant reflected on the importance of working within a sphere of influence and being able to communicate with others: “You need to be able to work with and represent nursing, community nursing, at external forums, at external groups, conferences. Participate. It's essentially leadership and visibility” (P07, lines 59 – 61). In both quotes, we see the participant enacting their agency. By putting themselves in a collaborative way of working, they can see themselves in a positive place to be visible. The participant highlighted their invisibility when working alone. This placed them in a vulnerable position.

Participant 02 described that they accepted how work was managed in the HCO:

> You need to be able to go with the flow. You have to be able to expect curveballs. Not ever expect to do exactly what you thought you might do every morning. And you have to always be positive. And supportive of the people around you, I think is the main thing otherwise people just won't work for you. They really won't. I think they'll move on, and especially in this climate, people can find jobs elsewhere, right? (P02, lines 439-444)

Using idioms such as “go with the flow” and “always be positive” positioned the participant as being able to manage curveballs. They acknowledged that despite being agreeable, they needed to be able to expect the unexpected in the HCO.

One participant positioned their ability to manage the relationship with their CEO to be creative:

> Oh, yeah, I had all sorts of freedom to be as creative as we wanted to be under the guise of and the guidance of the executive director. … So you have to learn how to manage that relationship as well. It's all about relationship management. It's all about relationship match. [laughing] (P12, lines 510 – 515)

The use of “guise” was interesting as it projected a note of concealment on behalf of the executive director. The participant portrayed the conflict in that relationship. They projected two conflicting viewpoints - one of sharing and resolving the situation and the other of deceptiveness. Another participant framed the environment in the HCO as combative:

> It was extremely combative. And I said, oh my lord, I'm so upset and distressed. So the tension. There were so many tensions at that table. … a truly disruptive environment. … From an executive perspective, this was not a team where you would learn and grow from except in all those ways that the benefit of these experiences is what to watch for later in your career, and a little better how to navigate it. (P06, lines 117 – 130 first interview)

The participant described the environment in the HCO as combative and disruptive. They indicated their invisibility and emotional challenges to enact their agency. However, we also see the participant enacting their agency as they move further in their career.

Four participants used “flexibility” and “nimbleness” descriptors to describe the attributes needed to manage expectations. These are familiar words nurses and nursing associations use to describe a trait of nurses in leadership positions. Two documents (D7 and D8) used these words when referring to a trait that leaders should have to be adaptable and to use as a strategy to manage stress. The participants disclosed being flexible within the rules and policies set by the HCO and the healthcare system. They positioned this within the conflicting system processes within the HCOs, which influenced the flexibility and rigidity of their NEs. In the following quotes, Participant 09 addressed the notion of being nimble or flexible to cope as an NE:

> I think it’s understanding and appreciating the context to practice, the environment that you’re working in … being flexible in terms of having rules that are foundational, but

> then there are opportunities to be a little bit more flexible. … I think being nimble helped me sort of cope through all of the changes that have happened over time. (P09, lines 88 – 95)

Later in the interview, Participant 09 stated: "Home and community care as a sector is quite unique, and requires a certain amount of flexibility, nimbleness, and a principled-centered leader" (lines 339 – 341). They acknowledged distinct types of knowledge circulating in the HCO - that of nursing and that of the organization, which required the participant to be nimble. However, the participant expressed that nimbleness and flexibility were only somewhat helpful. A second participant used the word "flexibility" to describe opportunities that were given to them by the HCO: "I've been, I guess, fortunate to have the flexibility to kind of make my own path within some structure" (P10, lines 34 – 35). Here, we see a contradiction portrayed in the participants' quotes. While they have flexibility, it comes with limitations. The third participant to use the word flexibility described it as a detriment to clinical care:

> They need to change some of their structures, if they really want that to mean safe quality, ethical care. … There's too much flexibility and how they meet it. No real discussion about budget and whether the budget is supporting safe, quality care. There's a lot of change that needs to happen there for it to be more meaningful and for it to be either a reinforcer of excellence, or motivator of change. (P04, lines 204 – 210 second interview)

Participant 04 suggested that flexibility in the non-clinical areas of the HCO is working to the disadvantage of quality clinical care. The participant notes their lack of flexibility within the financial constraints of the HCO:

> I think it's made me realistic. I mean, in many respects, it makes you think of how important it is to take your, responsibility or accountabilities seriously. I think rather than becoming embittered by it all, I think part of me enjoys the creativity of this is what I need to keep as many patients safe as possible and provide care to as many patients as possible. So how can that be done? And then pulling others into kind of doing that creatively? So although it's something that must be done, I've got no flexibility within that. Well, I've got a budget, I've got to stick within it. So how are we going to do this? (P01, lines 296 - 304)

The participant exhibited contrasting ideas. First, there was an opportunity for creativity, and second, there needed to be more flexibility to be creative. Overall, the four participants' narratives regarding nimbleness and flexibility demonstrated that the HCOs' environments established an interesting positionality for the participants to navigate the complexities of the HCO.

Participants were exposed to learned and established behaviours in the HCOs in many situations. They directed the interviews towards situations that, at times, constrained their ability to be effective, signifying the delicate balance of power to work around traditional culture within the HCOs. They often confront conflict by strategically managing expectations of themselves and others to meet their goals.

5.4. Managing Positionality

In this study, all participants deliberately assumed executive roles within HCOs. As mentioned in the introduction to this chapter, whether the participant reported to a chief executive officer or was the chief executive officer, they maintained their license as an RN. This was usually required for those within larger HCOs but not for participants who were in

independent practice running their businesses. In this section, I present results demonstrating how participants expressed their identity as nurses and executives. Their interviews reflected the tension in managing these two identities and exposed the underlying conflict of their identity as a nurse in their executive position. Participants showed how they established trust while achieving their goals as an NE.

Various organizational actors shaped how participants managed their professional and personal relationships, particularly with staff nurses. Some alliances created situations whereby certain participants felt jeopardized in their ability to express their nurse identity. This created a sense of precarity for them, which will be discussed later in this section. As a result, participants set boundaries to cope with those tensions. Examples of how participants represented themselves and how they managed organizational relationships will be discussed in the following sections.

5.4.1. Professional Representations

Participants exemplified how the social and political context within HCOs and the broader healthcare system shaped their identity.

Participants discussed how their identity influenced their perception of and outlook on the world. Throughout their interview, Participant 05 expressed an unwavering commitment to nursing. They described how being a nurse embodied who they were as a professional, whether or not they were in an executive position:

> I am a nurse for life. And that doesn't come and go. And my alliance professionally is with nursing. But that doesn't really make a difference in my ability to manage a system. It gives me additional knowledge and appreciation. So I am not a generic [executive]. When my clinical team came with a certain perspective, I was able to critically assess and respond and add value or shift based on my worldview as a nurse. (P05, lines 250 – 255)

This participant did not see being a nurse as an impediment to being an NE. Participant 05 clearly expressed the human aspect of homecare, and their nursing identity. They suggest clinical nursing knowledge was an advantage that gave them credibility with the healthcare professionals they managed. This participant associated critical assessment as an attribute of their nursing knowledge. Their identity and credibility were strongly linked to being a nurse. It was also linked to that of an executive.

Earlier in the interview, Participant 05 discussed having credibility with the HCO's other executives based on being a nurse. They identified themselves as "not a generic [executive]," suggesting that they used their nursing knowledge and position to their advantage. For this participant, being in an NE position was framed within their nursing philosophy.

Other participants conveyed a similar investment in enacting their nursing identity. For example, they strategically used their professional RN designation and emphasized their identity as a nurse when interacting with the staff nurses. The strategy here was to establish themselves as "one of them." Being accepted and recognized by the staff nurses showed how participants promoted their credibility with other nurses. The participant chose to elicit a specific identity to engage their work as an executive:

> I think it gives me a lot of credibility. And nurses like to talk to nurses, they'd like to know who's leading the charge is a nurse and understands what's going on. And also you can speak the same language and understand what the issues are. And especially if you've been there, nothing like having worked as a visiting nurse to be talking to visiting nurses. So it's very important to me, from an accountability perspective. (P08, lines 225 – 230)

Participant 08's reference to credibility reflected their understanding of their value as a nurse and their acceptance by the staff nurses. Phrases such as "nurses like to talk to nurses" and "know

who is leading the charge is a nurse" created a unifying discourse. The participant's identity as a nurse was critical to their relationship with the staff nurses and provided an essential vantage point from a leadership and management perspective. By emphasizing their previous work as a homecare staff nurse, they acknowledged that the staff nurses were comforted by surrounding themselves with like-minded individuals. This participant engages in their work with nurses in a way that serves to legitimize themself within that group. Participant 08 also presumed that because they had worked as a staff nurse in homecare, they "[spoke] the same language and [understood] what the issues [were]." Such a strategy rested on the assumption that homecare nurses constituted a homogeneous group.

By promoting their identity as a nurse, participants created a perception of a flattened organizational hierarchy. This demonstrated the importance of participants being accepted by the staff nurses. At the same time, participants suggest that their positionality as an executive was crucial to their role. Participant 08, in the above quote, used the word "accountability," which showed their understanding of their responsibility as an NE and the associated hierarchical power. We see interesting power arrangements between the participant's identity as a nurse and an executive and between themself and the staff nurses. While the participant had organizational and positional power over the staff nurses, they also showed sensitivity to reducing power dynamics between themselves and the staff nurses. We see movement between the participants' identities of nurse and executive.

Participants also legitimized their identity as a nurse by highlighting the complexity of knowledge they brought forward in the HCO and the healthcare system more broadly. One participant justified what they were doing to advance nursing care within the context of the organizational norms of the HCO:

> I think anyone in a leadership role has to define what their strengths are, what their competency is, because it brings to their overall leadership. So for me, in nursing, it [nursing] is a very important piece of what I bring into the healthcare space. … And now businesses, but especially in healthcare, I don't understand people who move into leadership positions who then don't just strategically legitimize their core of what they are. (P17, lines 174 – 179)

This participant identified strongly with their nursing identity as a measure of their knowledge and competence as a leader, emphasizing how the "core of what they are" should define and validate any executive's identity. This participant connected a leader's identity to that of an organization, thus proposing that an organization's value proposition validates their positionality. Participant 17 seems to shift from how others perceive them to how they perceive themselves as a business leader and a homecare leader: "It's an interesting question to ask me, How am I perceived? Am I a business leader? Am I a nursing leader? Am I a homecare leader? It's a very good question. I think it's all of the above" (P17, lines 400 – 402). The language used by this participant is not neutral. They expressed value and credibility in their identity as seen by themselves and others. We can see multiple co-existing identities of nurse, nurse leader, homecare leader, and business leader.

Participants strategically selected when and how to engage in these different leadership identities. P17 implies that these three identities can co-exist unproblematically and do not address some of the incompatibilities I highlighted earlier in this chapter. The participant conveyed agency with the nursing community, the healthcare sector, and the homecare industry. Later in the interview, this participant expressed the importance of not compromising the HCO: "You have to be careful that you don't actually compromise the organization to only be

recognized for yourself as the nurse, and instead the organization to be recognized for leadership at all levels of nursing" (P17, lines 199 – 201). Participant 17 emphasizes their role as NE less in this quote than in the previous one. The participant proposes that being recognized as a nurse can compromise the HCO. This is similar to the contentions that many participants have made, as discussed in section 5.2, that position nurses, including NEs, as less influential than other executives. Consequently, Participant 17 expresses a position of vulnerability to themselves, their identity as a nurse, and to the HCO. Their statement reflects the other executives ' power over the participant within the HCO. This complements and contradicts their earlier statement when they defined themself as a nurse, business, and homecare leader.

The following participant framed their identity and, consequently, how they represented themselves within their nursing goals:

> What matters is who I am as an executive, and what I can accomplish for the right reasons. And the right reasons are those people I'm working for. They're the nurses in the field, they're the clients, the patients that depend on us, my work is to support them. (P06, lines 219 – 222 first interview)

Participant 06's use of "right" connoted accordance with moral or social correctness. The notion of what is right and who decides what is right is significant. At the same time, this participant did not expand on how they defined "right," the "right reasons" may align with the norms and traditions of the HCO, nursing, or the healthcare system. Nevertheless, the participant defines these choices within a moral frame.

Other participants expressed a philosophical struggle in determining how to represent themselves. They often expressed tension between being a nurse and an executive. Participant 13 positioned this as keeping their nurse identity restrained to function in the HCO:

> I have to answer to my board. So I think that it doesn't really matter, that you're a nurse, it matters in terms, that sounds bad. It does matter. But you have to combine that with all the rest of your education and your experience to make yourself a good executive, or to be a good executive. It isn't just as being a nurse, it isn't. (P13, lines 374 – 377)

Participant P13 moved away from promoting their nurse identity and positioned themselves as an executive.

Embracing their nursing roots was vital to moving the nursing profession forward. However, as Participant 01 suggested, promoting their nursing identity, other health professionals shamed them:

> I think a lot of nurses over time have been shamed [by non-NEs]. We've had to, in many instances, give up parts of our nursing identity in order to thrive. And so I would say, don't do that. Now is the time, we [nurses] have to reclaim our space and embrace the future of nursing. And so I think that the game isn't over. (P01, lines 422 - 425)

This participant is embracing their nursing identity. However, this required the participant to make ‘parts of [their] nursing identity” invisible. Participant 01 brings forward a similar reflection that Participant 17 did earlier when speaking about their nursing identity compromising the HCO. Both participants experienced tension between their identities as nurse and executive. They contend that the discourses that minimize nurses and NEs are problematic. The value proposition in “shamed” brings forth the paternalistic culture of healthcare and the HCOs.

Other participants indicated they were cautious when using the title nurse to represent themselves. They critically decided when it was advantageous not to use the word “nurse” when introducing themselves. Participants sometimes let go of their nursing identity. Participants noted

that this depended on the context of where they were and with whom they were interacting. For example, when they represented the HCO with the government or non-nurses in external meetings, they were only sometimes comfortable promoting their nursing identity. Participants were not explicitly calling themselves or identifying as nurses, despite positioning their nursing identity as central within the interviews. One participant separated their identity of nurse and executive as they deemed necessary to accomplish their roles and responsibilities:

> Letters after your name - That means something to me when it comes to your expert opinion. But it means nothing to me about your leadership, or your style, or who you are as a human being. That gets assessed in a very different way. It's not associated with the letters. (P05, lines 214 – 217)

This participant expressed agency when they made continuous strategic decisions in identifying themself. They strategically concealed their nursing identity when challenged by circumstances that made it difficult to identify as a nurse.

Of particular interest in this sub-theme is that participants project themselves in the public sphere and as their selves as sometimes a nurse, an executive, or both. Whether their title and identity as a nurse became a liability, participants used the term nurse in their title, depending on whom they conversed. They sometimes dropped nurse out of their NE title to be respected as an executive. Participants strategically made their nursing title invisible when introducing themselves in specific forums, such as meetings with executives who were not nurses. Participants were still able to impart their nursing knowledge.

5.4.2. Strategic Alliances

Participants discussed developing relationships with actors within and external to the HCO. They wanted to reach out to NEs in other HCOs and executives outside of healthcare.

They also discussed building relationships within the HCO with their CEO, the other executives, and the staff reporting to them. In all these situations, participants attempted to strategically create alliances to enhance their ability to navigate the complex environment within the HCO. Participants discussed the concepts of collaboration and alliances. They suggested that collaborations were about working with others towards common goals. In contrast, participants framed alliances as longer-term partnerships that benefited all parties.

Participant 08 also described that their relationship with the CEO influenced how effective they were in their role as NE. They exposed how they were in a position of power as an NE, simultaneously recognizing the other executives' power:

> Well, when it's all together, it's very easy, because, at the end of the day, next to the CEO, I am the final decision maker about how these things run. But I think that it really, by having them [the executives in the HCO] together, it just allows decisions to be made more quickly. It allows me to bring the right people together to make the decisions. There's not kind of this hierarchical up, over, back down again. So communication happens much more quickly. Decisions are made, things are acted upon. (P08, lines 107 – 112)

Participant 08 put themselves in a position of power and authority. Their nursing identity and knowledge strategically removed barriers. Validation by the CEO enhanced the participant's credibility and position within the HCO and among the other executives. However, they also described a culture that reflected their power over others. The participant depicted a traditional management structure within the HCO while at the same time naming it as not hierarchal. This participant enacted agency by controlling decisions and transforming the traditional hierarchal structures into collaboration.

Another participant suggested that collaborative decision-making within the HCO went beyond their relationship with the CEO. They expressed the view that working independently made it challenging to get buy-in for decisions:

> I'm building relationships with all of the senior directors, with the nursing managers. … I learned the hard way that you have to have people on board to help you move things forward, especially when you're in a position of influence. (P11, lines 166 – 169)

Participant 11 strategically developed relationships with the executives and other senior-level people in the HCO. They suggested that they were in situations where they made mistakes. They also reveal that those were difficult and perhaps painful experiences. The participant advanced their agenda by creating these relationships and offset receiving a negative response. This required effort on the part of the participant to facilitate and maintain those relationships. Participant 11 felt obliged to promote their nurse and executive agenda, depending on with whom they built relationships. Despite suggesting the need to collaborate, Participant 11 expresses an opposite environment. Participant 01 describes collaborative situations across different HCOs:

> I have a philosophy that we're [HCO executives from various HCOs] stronger together. And so, let's put politics aside, let's focus on the patient experience, let's focus on what's needed. Let's focus on the staff. And let's build this together. And so I think that's when I feel most successful. So let's put competing business interests aside, competing funding issues aside and really look at what's best and how we can do this collectively. (P01, lines 237 - 242)

Participant 01 strategically manages negotiations and transactions to advance their agenda and build strategic partnerships. They present an ideal view of healthcare, which is different from the prevailing discourse. This situates Participant 01 in a tensive position between their expectation of working in homecare and the reality of the competitive sector.

Document 2, mentioned by participants, promotes effective leadership within a shared decision-making model. This document illustrates a specific discourse about nurse leadership that promotes collaborative structures:

> "Effective leadership is demonstrated by staff participation in decision making, the philosophy of the organization and the style of individual leaders within the organization. Possible strategies include developing a nursing governance structure to address all nursing practice issues; providing opportunities for nurses to enhance their individual leadership skills within a defined role; creating mechanisms to help nurses manage professional role conflict effectively, as it arises, on a one-to-one and collective basis." (D2, p.12)

While the document suggests committees and other organizational structures to engage staff, it offers a very apolitical take on organizational relationships. It does not go further in offering NEs tools to develop strategic alliances. This is a missed opportunity to propose strategies that could benefit NEs.

Participant 09 recognized that various knowledge and discourses were circulating within and outside the HCO, and situating the opportunity to leverage relationships in order to share knowledge was sometimes problematic: “There weren't a lot of I'll say peers that I could connect with to really appreciate what the sector was all about” (P09, lines 18-19). They stated that relationships within the HCO and outside of the HCO were necessary:

> You don’t just come into an organization and start zero, you’re leveraging people’s experiences within the organization, outside of the organization. So that shapes the forward thinking, right? Because you want to leverage people’s experiences, and you want to be able to stretch their experiences to something that is, perhaps more innovative and inclusive, given the changing environment. (P09, lines 112 – 116)

By “leveraging people's experiences,” this participant used very corporate language, acknowledging that they were using others' knowledge to their advantage. Later in the interview, Participant 09 discussed creating safe spaces to speak with others: “Well, you create that safe space, to have that kind of dialogue. … So I think you have to be able to look within and external, to be able to shape the future” (P09, lines 118-121). We see an interesting scenario depicted by this participant. They noted accessing others but not recognizing them as peers, suggesting relationship challenges.

Another participant stated that sharing knowledge was tricky:

> So what I what I found is that at that [executive] level, and I know that other people have said this, is that you can't really go up for support, … you have to be careful because they don't have a lot of time. You can't really. It's tricky when you start involving your team. … And you can kind of talk a little bit, but you can't talk too much because they talk and then they'll get worried. And so you have to be careful that way. (P12, lines 295 – 301)

The participant exemplified their isolation in sharing information. They simultaneously conveyed how they manage the flow of knowledge up the hierarchal ladder and to people reporting to them. They created an image of knowledge circulating in the HCO that was not visible to everyone. This intensifies the challenges of developing and maintaining constructive

relationships. Participant 13 also described their relationships with NEs in other HCOs and the need to be careful about what they discussed:

> I wanted to talk to [another NE] about nursing. And, just like, how are you managing with recruiting? And how are you? You know, [conversations about] best practice, … but you couldn't give out too much information. You just couldn't. Like if somebody was starting something new, it was all undercover. (P13, lines 311 – 316)

While this participant disclosed that those relationships with other NEs were essential, they conveyed that encountering other NEs with similar experiences was challenging. They express mindfulness of the risk of sharing corporate strategies that could compromise the business of the HCO. This situates HCOs as private enterprises.

Participants discussed their relationships with the nurses who reported to them. They noted that developing relationships with the staff nurses in the HCO was essential to meeting organizational goals.

> There's many other components that are necessary for the [NE] to be effective. And then how the [NE] works with their clinical leads is an interesting dynamic. And that's where, again, if it is very hierarchical, that's something if it's more a sign of collaboration than what makes sense. Because we know, and ultimately ended the day, the [NE] is accountable. Yeah. And it's not like I can say, Well, I didn't know, there were all of these issues you have part of your role is to have the pulse points. (P17, lines 379 – 385)

One participant conveyed how they strategically designed daily transactions to build staff trust and ensure HCO loyalty. They acknowledged this and recognized the importance of professionally supporting the staff nurses:

> P10: I always want people to feel they can come to me with whatever they want to they should never be fearful of bringing anything to me.
>
> Researcher: How do you do that? How did you do it before COVID? How are you managing it now?
>
> P10: Yeah, I think it's, I mean, fortunately, we do you have a number of staff who are long standing. So over the years, we've built that relationship, but just taking the time to ask how their family is and just like taking interest in them, not just all job focused. Right. (P10, lines 71 – 80)

The participant suggests that the HCO is both a positive and harmful environment. The word "fearful" signifies the power differential between the participant and staff. It connotes anxiety or apprehension on behalf of the staff. This creates an interesting contradiction when speaking about building relationships.

As staff worked for multiple employers, the participant considered building trust and loyalty necessary. The participant tried to ensure that staff nurses remained at the HCO rather than move to other healthcare settings due to higher salaries and different working conditions, as discussed in section 5.3.1. Participants created allegiances by making themselves available to staff through formal and informal meetings, social events, and gifts. One participant described the use of symbolic gestures to establish meaningful relationships:

> So I try to be very, very generous with them, financially generous with them in terms of parties during the year, gifts that I send them. So generosity, I think, is really helpful to getting nurses to want to collaborate, they just want to feel appreciated for what it is that they bring. (P03, lines 221 - 224 first interview)

Participant 03 expressed an extremely positive attitude and intentions. However, they also suggested challenges in employing symbolic gestures with the staff nurses. There were no guarantees that those actions would have the desired effects. Nevertheless, better working conditions, salary, and access to resources were more likely what participants felt the staff were anticipating, as discussed in section 5.3.1.

We see a similar reflection from Participant 07: “Whatever structure you use, you need to create an opportunity for your nurses to support each other, interact with each other, learn from each other, celebrate each other, and where the organization can celebrate them” (P07, lines 55 – 58). Participant 07's use of the idiom "your nurses" connoted ownership of and power over the staff nurses. It also reflected the paternalistic structure of the HCO. This way of describing their actions reflected normative behaviour in HCOs and other healthcare sectors. It created an illusion of a horizontal organizational structure within a hierarchical one.

Participants developed formal and informal contacts with executives outside the HCO and the healthcare field. They conveyed the importance of fostering and maintaining those relationships. However, they described needing to be cautious. Similar to Participant 09, the following participant reflected on the risks of their role of NE. They stated that the higher they were in the organizational structure, the fewer peers they had:

> I think it's got very little to do with whether I'm a nurse or not. The higher up you go, the fewer peers you have that you can really say to them, this is a disaster, I'm in the middle of a disaster. You just don't do that. So I think that this is where there are groups that I would look to join who would be not necessarily be nurses and not even healthcare, to be honest with you, I would go for the non-nursing, non-healthcare, right group. This is also where it's important, is to have solid people outside of work, you have to find your

> networks of support yourself, that's your job. If you're feeling isolated and unsupported, you better do something to fix it. I wouldn't be looking for somebody else to fix it for me. (P07, lines 384 – 394)

Being “in the middle of a disaster” constrained these participants' opportunity to speak as openly as they might have otherwise to other executives in the HCO. This inhibited the flow of information within the HCO at a time when working collaboratively to resolve a crisis would be opportune.

Participants were concerned about how other executives interpreted their comments. Therefore the participant constructed circumstances to enable their agency by speaking to non-healthcare people external to the HCO. This allowed the participant to speak more openly. There was protection in discussing issues about the HCO with executives who did not work in healthcare and would not necessarily have the knowledge to counter their comments. Therefore, the participant placed themselves in conversations with others who could be supportive. This was strategic as the participant believed there was no choice but to take full responsibility for resolving their isolation or lack of support. Another discursive move by the participant was their perception of vulnerability. Participant 07 saw vulnerability as a trait to correct because they saw it was unacceptable at the executive level. It could expose corporate difficulties that could jeopardize the business aspects of the HCO. We also saw that the participant did not expose their perceived weaknesses to themselves or others. They considered it advantageous to be independent and self-reliant, even if it exacerbated participants' isolation.

Another participant reflected on the difficulties of reaching outside the HCO for allies. While they noted that they could speak to the other executives within the HCO, they identified organizational competitiveness that made it difficult:

> So I know that people have networks of other directors or executive directors or managers that they connect with. It's hard to do it in the organization because the problem is [the other executives], you can only talk so much because, as I said, they're into it for their own programs. … And what I've heard is that various people have set up networks of executives of different organizations, because that's not as threatening. But within an organization, I haven't realized that at the executive level, there's not a lot of support for learning, and your [CEO], expects you to just be there and just organize it They're not as open. Well, that's not really their role. (P12, lines 307 – 317)

The participant searched for a safe environment for themselves. They moved outside nursing and healthcare communities to find allies. This participant intentionally makes circumstances for sharing their knowledge in a safe, non-confrontational environment, thus enacting their agency. They express vulnerability in their position as NE within their HCO, proposing the need to go external for support. Another participant identified the risk of having informal relationships outside of the HCO:

> I think the complexity of the environment is underestimated, the complexity of the relationships that we have with system partners, is very underestimated. … Those are very complex relationships, because at the end of the day, they are a business relationship. And so that, again, makes it very difficult sometimes to navigate. (P01, lines 317 - 322)

The participant indicates that they navigate difficulties within the HCO and externally. They position their external relationships as susceptible to personal and organizational risk. Participants are situated within a work environment that enhances organizational goals at the risk of personal agency. The participant further discussed the concept of business relationships:

> It's always about who's jockeying for position. If unlike again, you have to be careful about what information is shared. Because it, it, it can be used to bolster somebody else's position or denigrate your own position. So it's this kind of weird world that we're in. (P01, lines 377 - 380)

Here we see relationships that augment the outcomes of the HCO. The participant described "jockeying for position," an idiom that connotes putting the HCO in a better financial position than other HCOs. Again we see a participant protecting corporate secrets. The phrase "bolstering someone else" suggests that it was not advantageous to support other HCOs. The portrayal of a business model is evident in this quote. Working for a private organization challenged many participants when they attempted to develop relationships within and external to the HCO.

Participants indicated opportunities to speak the truth with NEs and healthcare executives in other HCOs. They describe navigating the competitive nature of the homecare sector. The oversight of the system partners, the government officials, added extra difficulty to establishing relationships and support. A participant positioned those intricacies as having their voice censored:

> I believe we [NEs] are censored [by the College of Nurses of Ontario]. I don't think that's new. It's just that there's more on the line right now [due to COVID-19 pandemic]. … If I didn't censor myself, I think I would be suspended, probably or I would risk suspension and I'm not big on conflict. So I'm more likely if I wanted to feel like I could say what I need to, I would probably resign my [RN] license. Because I don't want to be in conflict with the [nursing licensing body]. It's not worth it to me. I can do my job right now. … I could carry on doing what I'm doing. (P03, lines 524 - 532 first interview)

This participant suggested that the concept of censorship was not new. However, they noted that the COVID-19 pandemic had exacerbated their vulnerability to speaking out and feeling safe. They positioned speaking out as dangerous due to the risk of being disciplined by the College of Nurses of Ontario. By sharing information, the participant felt they were compromising and putting themselves at risk professionally and personally.

Participant P03 stated that their nursing license was not critical to their nursing identity. This creates an interesting conflict with their nursing identity. One discourse proposed by the regulatory nursing body states that nurses can only identify themselves as RNs with their licenses. However, this participant states an organization's authority does not define their identity as a nurse but rather that it is integral to who they are, suggesting agency. However, Participant 03 suggests they wanted to avoid conflict with the nursing licensing body, signifying the power of that organization. It is interesting to note that the censorship that this participant discussed was self-imposed. The participant was managing the risk of losing their license.

Another concept that arose in the interviews was when participants reflected on whether they were in a privileged or influential position in their role as an NE:

> I don't really feel like I'm in a privileged, influential position. And yet, I have people who call me their boss. Whenever I hear that, I think, Wow, I'm not really anybody's boss, am I? … But privilege? I don't know. I just, you know, what? I actually feel like all nurses are in an influential position because I think people listen to us, because we're nurses. … So it probably means I have influence that I don't capitalize on or even think about it much. Because I think you could capitalize on that you could use it to your advantage. But I know, but I don't really think about it much. (P03, lines 484 - 492 first interview)

This participant aligned themselves with other nurses. This builds on the rhetoric that all nurses are leaders, which was prominent in several documents. Documents 1 and 2 mentioned that leadership occurs at all levels of nursing within an organization, with the focus being on patient outcomes for clients.

Participants censored some information about HCO initiatives aligning this censorship with keeping corporate secrets safe. They observed censorship of information within the operational culture of the HCO. It contradicted the following participants' understanding that homecare was about collaboration and delivering the best patient care possible. Competitiveness was also occurring within the HCOs. As we saw earlier in this section, Participant 12 reflected on other executives' different intentions in the HCOs based on their specific programs. Later in the interview, this participant expressed surprise that the executives in the HCO did not work collaboratively:

> I always thought that we're in it for the good of the organization. Well, no. We're into it for our own reputations, which is very clear. … And then, if we happen to be able to work together, that's fine. But then you have to be careful about that. Who [which executive] gets the credit? (P12, lines 323 – 327)

Participant 12 revealed that their belief in working within a team model differed from the HCO norm. While this was not overtly stated by other executives, the organizational customs and rules within the HCO prohibited the participant from working collaboratively. The participant attempted to share and acquire knowledge circulating in the HCO.

Participants described situations where they communicated candour in relationships with other NEs and executives. They noted that this was not unique to healthcare, nor was it an

expectation. However, NEs indicated that this contradicted how they had been socialized in nursing, whereby healthcare was a team endeavour:

> You have to build horizontal and vertical relationships. Without powerful relationships, including board members and executives, you're a dog's breakfast. Because the minute you try to do something that is important, and other people don't like it, they will kill you. So relationship is fundamental. (P05, lines 220 – 223)

The participant used "a dog's breakfast" to describe disorganization. Here, the participant took it further to address the failure they may have personally confronted without strategic relationships with those above and below them in the hierarchal organizational structure of the HCO. This implied the need to manage relationships and build buy-in carefully. Without this, the participant experienced vulnerability and the reality of a threatening professional environment, as demonstrated when they used the term “kill.” They must build operational support for their agenda to offset this unsafe environment.

Participants felt the need for collective support from NEs in other HCOs. Despite HCOs being competitive, participants believed there were opportunities to improve patient care in the homecare setting by working collaboratively. This called for them to put their competing interests aside and to work towards mutually common goals. However, despite the need for allies, creating opportunities to establish professional support and collaborative allies took too much work for participants:

> So there's that piece of knowing all your stakeholders and rather than because, believe it or not, many people are competitive with their stakeholders, and this is about getting something to happen. This isn't about who is making it happen. It's about getting something to happen. So work with that group very well. (P17, lines 394 – 398)

Here the participant was challenging the social relations and attitudes of the HCO and the homecare sector. Creating strategic relationships with others external to the HCO required knowledge of who those individuals were who had a similar vision. The participant expressed incredulity that the knowledge that homecare is competitive had yet to be widely known. This is interesting, as the participants described HCOs as businesses that engage in making profits.

We have seen in this section that mobilizing others within and external to the HCO created complexities for participants. While trying to create environments of cooperation that focused on common goals, participants needed to be careful with whom they developed strategic alliances. Participants often described their relationships as censored by themselves, others in the HCO, and other executives within the healthcare system. While those narratives exposed the participants as censored, they also reflected the participant's agency in controlling the flow of knowledge. Participants also described alliances with others that offered shared opportunities and created collaborative advantages. Those alliances often bolstered the HCOs' business strategies and created competitive advantages. Participants could purposefully limit competition with other NEs in different HCOs.

5.4.3. Sense of Self

This section discusses how participants exhibited their sense of self. Participants reflected on how they managed situations they perceived as threatening to their identity and self-worth. They also disclosed managing their relationships with themselves. Participants described focusing on themselves using various strategies to cope. Participant 03 expressed a position that linked their personal and professional identity: "If your relationship with yourself isn't solid, then I think your business won't be, because it's depending on you to be solid in your relationship with yourself. … So I'm just careful not to make decisions too quickly". (P03) (Lines 289 - 297 first

interview). This participant recognized that external influences affected their sense of self. They presented organizational issues within the HCO and confronted their relationship with themself. They revealed the importance of self-awareness and self-care as an important connection with their ability to function as an executive. Participant 03 suggests that external contexts influenced their identity and that their self-preservation relied on consistency and purpose. They created safe emotional spaces for them to succeed in their role as NE.

Participants depicted situations in homecare that either sustained or undermined their sense of self. In some situations, they underwent threats to their identity and their sense of self. Their relationship with themselves is portrayed by how they perceive themselves. Participants also portrayed how they enacted their moral and epistemic agency. Participant 12 presented vulnerability in themselves: “You want to have a really optimistic outlook. Once you start getting pessimistic and pissed off, you're finished. … You really need to watch your back. You have to have eyes in your back” (P12, lines 653 – 660). The participant indicated feelings of vulnerability through their use of the idiom “watch your back.” They portrayed the HCO as an organization where they expected to be in a safe, professional environment where they could have influence. However, they presented an unsettling organizational culture that promoted conformity.

Participants shared scenarios in the HCOs that put them in other precarious positions. These situations created emotional uncertainty within participants. They were living through experiences which they described as undermining their credibility. These experiences elicited those participants to question their self-worth and identity as an NE. One participant expressed how this affected their ability to function personally and professionally: “So you see what happens is then you're not functioning at your best. You're not emotionally strong. And you don't

do your best work, and so it becomes a spiral, and I was very conscious of that downward spiral" (P06, lines 256 – 258 first interview). Participant 06's language expresses tension and dissonance. It is interesting to note that later in the interview, the participant equated this as a career lesson that helped them to recognize burnout in themselves and others in the future. They reflected on how they understood the impact of how precarious they felt and how other NEs could also feel.

Similar to other participants, Participant 04 struggled to align their values with those of the HCO. This created a situation whereby they could not sleep at night. They described a change in executive leadership that altered the organizational culture and values of the HCO:

> Researcher: Could you sleep at night?
>
> P04: Not in the end. All the way through? Absolutely. I never actually had a problem working for a for-profit, obviously, [for more than 20 years], would be crazy to say I did. Because leadership [at the executive level] always had the right values. But in the end, the values had completely deteriorated. to be able to realize safe, quality, ethical patient care with the best possible outcomes was very difficult. Very difficult. [subdued voice] (P04, lines 264 – 270 first interview)

This participant maintained their sense of self and identity as a nurse and executive until the situation became untenable. In the following quote, we see how this participant attempted to manipulate the discourse within the HCO, enacting their moral and epistemic agency:

> And so I tried to reconcile that a lot of times by doing the work around, articulating, why is it important, why does it matter? I always used evidence, whatever evidence I could find, whatever problem I was trying to negotiate around. But the dollar really was key. So

> then I pivoted a bit, because I said, okay, if they don't want to use the right qualified person, at some point in this in this trajectory, you're going to find out that RNs are not going to want to come to work here. And when you need an RN, you're going to be in the very position you are now by not using them, it's going to backfire. (P04, lines 242 – 248 first interview)

Other participants expressed their moral and epistemic agency, contributing to their sense of self. The following participant expressed moral distress in their role as NE:

> So my values were that we are here to serve the communities we serve. We are here to take care of people and families, not just give them the ten-minute care. Okay. I believe in working closely with communities and working closely with staff. (P05, lines 107 – 109)

The participant exposed moral conflict in working within an HCO culture with limited resources. Participants enacted their moral agency, often stating or inferring their perceptions of correct and wrong decisions. They centred their self-worth on their accountability for their actions. Participants also reflected on their experiences and connected them to their identity as a nurse and executive. Later in the interview, Participant 05 revealed the vulnerability to themselves that caused emotional suffering:

> I was driven by my values and care for the agenda. And that sustained my being punched down and get up and go again. But a lot of pain, a lot of emotional suffering, not in a clinical way [not in a way leading to a clinical diagnosis], but in a caring way. (P05, lines 126 – 129)

This participant maintained their sense of self despite “being punched down.” However, experiencing emotional suffering suggests the unsustainability of their sense of self. The following participant raised the exposure of participants to situations that elicited vulnerability:

> I do look around me sometimes, and I think, gosh, there's a certain amount of jadedness in nursing leadership, and that saddens me and actually makes me a bit fearful, I think that I'll be there one day. But I don't want to be jaded I want to still have that passion and that adrenaline. But it does. … Sometimes the politics just gets a bit much. (P01, lines 262 - 266)

Participant 01 wanted to maintain interest and excitement in their role as NE. They reflected the impact of the homecare politics of homecare discussed in Section 5.1. where they were demonstrating an autocratic culture in HCOs:

> P01: But I have to say, it's a hard slog. It's a hard slog, and I would have to say, as well, that the hard slog outweighs a lot of the kind of the good days.
>
> Researcher: Tell me about that. What that means to you from a nurse perspective from a person?
>
> P01: Yeah, I saw, I think what it means is, I tend to kind of refocus, sort of away from my own needs. And so I do think it comes at a cost to my family life to perhaps my health at times. And, yeah, and just [*pause*] sort of focusing just to get something done. (P01, lines 244 - 251)

Here Participant 01 indicates the professional and personal toll the organization structures created. They created an image of having to struggle through their daily interactions and focus their line of sight toward the goals of the HCO. Again, as with Participant 06, we saw recognition

of self in this participant having to refocus away from their own needs. It is worth noting that this protection of themselves and their identity reflected the participant's agency.

The following participant demonstrates the importance of line of sight as an NE. Their identity and agency depend on how they manage within the HCO culture:

> I do think in nursing, we're never wrong. We don't want to be wrong. Like we never from a clinical point of view, go, oh my goodness, I'm going to do this and it's going to be wrong. So what do I think about this? So you're never wrong. When you move into leadership, you're always wrong in the sense of a different idea. What do you think there's always an opportunity for improvement for progress for what needs to happen? Where many times in the clinical practice it's a different line of assessment, diagnosis, intervention, evaluate… but there's also this emotional thing of you're not making mistakes, you're right with what you're doing. And a lot of the things in management and leadership are new solution generating, so you're going to get it wrong, or you won't have all the information. (P17, lines 436 – 448)

This participant indicated that there was a responsibility to make decisions that were sometimes right and sometimes wrong. The participant described this as emotional, illustrating tension in the discourse in the HCO. They also indicated that their knowledge could be invisible in the HCO, not knowing what was occurring.

Participant 12 raises challenges related to the private funding model in HCOs, as I noted in Section 5.2.1:

> What puts you at risk is the fact that it's all privately funded. And so it's completely dependent on that money. … But no, I never felt at risk for discussing anything. No. I mean, you just have to be savvy, you have to know what you can say, and what you can't

> say, but I suppose it could put you at risk. But I never felt that. But I was always really good at trying to create allies. Yeah, so that, yeah, that that was never an issue. (P12, lines 372 – 377)

The participant described conflicting discourse and knowledge circulating in the HCO. The participant exposed their agency by making specific knowledge visible or invisible depending on the situation.

Participants disclosed that they created safe spaces and set boundaries to control their daily transactions and negotiations within the HCO. Participants presented a pattern of being resilient in their narratives while not always naming it that. However, many participants used the idiom "being resilient" when describing an attribute they possessed. One participant portrayed being resilient as being flexible and adaptable:

> Resilience is that you don't give in to the worst, or the most energy robbing of your feelings, you find a way through it. And you've got to just hang on, there's better time coming. … So that as you go into your career, you should be building that muscle of resiliency, because you learn. (P06, lines 408 – 412 first interview)

This participant portrayed dealing with highly stressful situations, which caused them distress. They discussed a “muscle of resiliency,” a shared discourse in nursing and leadership. It depicts being tough and having the strength to deal with conflict. Document 7, widely read by participants and used in the CHE leadership program that some participants took, suggests that resiliency is a muscle that someone can build. The document identified resilience as one of the qualities of leadership. It promoted a resilience scale and stated that: "Resilience comprises many other elements of character including integrity, adaptability, patience and courage. Recent research suggests, similar to emotional intelligence, resilience can be developed like a muscle, in

both people and organizations "(D7, p.92). These scholars contend that resilience draws on an individual's emotional and moral strength. The concept of resiliency as a muscle was supported in Document 8, edited by four healthcare professionals, one of whom was a nurse. The document described the nursing profession as resilient. It positioned NEs as leaders in developing resilience skills.

The following participant noted the merit of being resilient:

> I don't think there should be secrets there … I wish I could tell everybody, … if there is one attribute that will save them every time, it's resilience. And you know, all of those things that [the experts] tell us to take care of, to take a break, when you have to put a vacation in the book, so you can see it coming, or you won't survive, you have to know that, that people will just keep going with you, they won't understand that you're at the end of your rope truly, and you've just painted a face over it. So you have to do those self-care things. (P06, lines 395 – 402 first interview)

Participant 04 positioned resilience as a coping strategy to survive and continue to function as an NE. They expressed that they experienced pressures that required self-care, suggesting that those situations were demanding. Self-care was a strategy for this and many participants to survive being an NE in an HCO and the homecare sector within the broader healthcare system. In the participants' views, they needed to take responsibility for themselves because no one else would do it for them. They needed to create those opportunities and establish boundaries.

Participants described needing to resist those situations, whether visible and named or not, that caused them distress. Participants used phrases such as "you really need to watch your back," "it's a hard slog," "keep your head up," and "sustained my being punched down and get up and go again." They verbally used emotive idioms to explain that they were at risk of feeling

tired, jaded, in error, or losing their job. Document 6 described that the "outcome[s] of investing in the health and wellbeing of nurses" (D6, p.47) was to build a resilient healthcare system. Earlier in the document, it stated: "While the [nursing] profession has been extraordinarily resilient, there were high levels of poor mental health and wellbeing caused by workplace issues" (D6, p.45). This document conveyed conflicting discourses, one of nurses being resilient while having poor mental and physical health. It is interesting to consider why participants felt personally responsible for organizational problems.

Some participants reflected on the social context of healthcare by using idioms such as "bounce back to cope," or "it's my responsibility." Their use of “resilience” connoted a long-term behaviour required in their positions as NEs. However, participants did not position the issues causing their need for resilience as related to the organizational or systemic processes. Other participants created boundaries for themselves that involved linking their identities as nurse and executive:

> I hope I haven't been too negative. I think there are lots of pressures facing nursing executives, particularly in this space, at this time. But I also think that there's a lot of opportunity, and, to really carve out what nursing leadership looks like, in the future. And if we can kind of put aside that those kinds of competitive urges and really refocus, sort of to what it means to be a nurse, in terms of patient care, in terms of the other nurses around us, then I think that the future we can build a new future. (P01, lines 435 - 440)

Participant 01 portrayed two notions: one of the significant pressures and the other of having opportunities as an NE, which conveyed quite different organizational cultures within HCOs. The participant exposes the current social order in HCOs for NEs as competitive. They then

propose disrupting the current beliefs and behaviours towards collaboration, focusing on patient care.

Most participants constructed a discourse of liking or loving their careers. Participants often framed it around their identity as a nurse. Their narratives reflected their need to be positive, appreciated, collaborative, and respectful. Participants maintained a position where they expected minimal critique. This was almost untenable for those participants who saw themselves as the only solution to improve patient homecare. Participant 10 presented uncertainty as they wavered between feeling at risk and reflecting on liking their job:

> Researcher: Do you ever feel that you're at risk in your position?
>
> P10: Sure, yeah. There certainly are times that I think Yeah. Oh, gosh, Yeah, I do. … Yeah, I mean, you never know. But then I just say, oh, kind of take a step back and say, well, I do like, at the end of the day, 95 per cent of the time, I like what I do. Right. (P10, lines 393 – 396)

Participant 10 presents a flow of ideas through their hesitation. A level of personal protection and setting boundaries is detected in their reflection.

Using the idiom “at the end of the day”" projected a sense of self in setting limits to determine what was most important to this participant. The third participant to express liking their job placed their challenges into a short term:

> And what I learned is, I hate it today. I'll see how I feel tomorrow. So never to take the moment you're in as the reality forever. [speaking emphatically] That is the biggest important thing I learned through that trajectory. Never take the moment you're

> experiencing now as the forever scenario. Give yourself time and space. And then you can decide more pragmatically. . (P06, lines 381 - 384 first interview)

In their interview, Participant 06 evoked emotional precarity while reflecting on how they made continuous strategic decisions in their daily transactions. Their words express the possibility of leaving the organizational space, moving into their personal space, and surviving intact. Participant 06 creates this image of an artificial separation between their professional and personal space where their identity as nurse and executive remains at the HCO.

In all three of the quotes above, the participants' speeches reflect that they are doing anything to make things work properly. They rely on the discourse that nurses must endure stressful situations without complaint. Their narratives suggest that they expected to cope better, internalizing failures. These participants expressed agency in their choice to accomplish operational goals for their staff and people receiving homecare services. They directed their agency as both a nurse and an executive.

The need to be autonomous often led participants to deal with the consequences of their decisions and actions. Living with that responsibility sometimes meant separating their nursing and executive identity. Participant 17 moved between using the words "we" and "I" when describing different situations:

> I'm competitive. So if we made a mistake then get on the other side and go, Okay, let's think this through, and let's make some sense of it. And that's the being real of how these things play out. And that's where some people kind of think they're not real, because your initial reaction is always some way of disappointment, then working through it and going, Okay, why did we miss that? I try to always depersonalize it. And that's where I go, everything is a 'we.' What did we do differently? What did I do? Is there something I

> could have done differently? Why didn't ~~I~~ have enough pulse points on that? (P17, lines 300 – 304)

They used "we" when speaking about themselves and others within the HCO. The participants also used the word "we" when describing themselves as an element of the HCO. In contrast, they used "I" when speaking about themselves as an individual nurse and executive. This movement between participants' collective and individual voices was interesting. They evoked different culpability for decisions made by themselves or other executives in the HCOs. Then later, the participant:

> If you need your ego defined, every mistake is your mistake. And every celebration is everybody else's, and that's what it should be. So you need a strong ego. And that's where also you need to work where you're happy, because you're going to go through that all the time. And if you're not happy, that's where you're going to be, well, I was working really hard on that idea. And you'll be kind of bitter with things. But ultimately, you're happy and you understand the role of a [NE] and, and the energy that's needed in the organization. And that's what your role is, is very different than it never is, it shouldn't be all about you. Right? Now, if it is, you're not going to be in that role for very long. (P17, lines 319 – 327)

As we saw in the narratives, participants, such as Participant 17, were often in situations with conflicting ideas and ideologies. They actively positioned themselves in various circumstances that sometimes surprised them with the personal toll it took. This may be a symptom of how that healthcare system works, how it positions them, and what it puts them through. They often felt the need to navigate challenging situations and maintain control of the flow of their knowledge and expertise through their organizational and interpersonal relationships. Participants also had

to manage the other executive's knowledge about themselves and their roles and responsibilities to keep the clinical and operational functions of the organization working. The choice of language that the participants used reflected the burden they experienced, which centred on the responsibilities they felt to correct improper knowledge circulating in the HCO, the healthcare system, and the public.

Chapter 6: Discussion

My study presents a critical analysis and original theoretical approach to a complex phenomenon that scholars have yet to theorize or analyze. It addresses current gaps in our understanding of the experiences of NEs and their organizational positioning in HCOs. It explicitly addresses the types of knowledge deemed valid and useful yet ignored by healthcare professionals. My research includes three dimensions that make it unique to the current body of scholarly work in nursing.

First, as I noted in Chapter 2, while scholars have examined the homecare sector and homecare nursing in the literature from the perspective of point of care, HCOs have yet to be approached as distinct entities. My study pays equal attention to the function of dominant discourses and practices in HCOs that foster specific ways of thinking, speaking, and acting across those organizations and within the healthcare system.

Second, as discussed in Chapter 2, research needs to explore the positionality of NEs in the homecare sector. NEs' experiences of their dual identity of executive and nurse in HCOs have yet to be examined. The hierarchy within HCOs provides direction and belonging for individuals working within the HCO, which creates and enforces order within the HCO and creates inequities among the executives. My arguments situate this research to explore NEs' moral, socio-professional, political, and epistemic agency in HCOs as distinct epistemic landscapes.

The final distinct aspect of this research is my use of a novel theoretical framework of CMS, as informed by Foucault, and the SoI to demonstrate the complexity of NE power within the context of social structures. This study exposes the relationships and the circulation of knowledge and non-knowledge (i.e., ignorance) and the ability to exercise power within HCOs.

NEs use ignorance to move their goals forward while being kept from knowing something or being de-legitimized knowers through routine organizational activities, discourses, and priorities.

Maintaining what we, as nurses, understand regarding leadership positions, responsibilities, governance, and collaboration should be easy, but it is not. NEs partake in the leadership discourses upheld by nursing associations and regulators. They are presumed to manage their expectations and those of others within corporate structures and the healthcare system. I had candid conversations with participants about what is happening in homecare and what they believe is needed from themselves, the HCOs, provincial policymakers, and regulators to ensure quality nursing and patient care. After conducting interviews for this research, some participants continued to reach out to me, showing enthusiasm for their roles and responsibilities and seeking improvements in nursing and patient care in the homecare sector. They have expressed interest in collaborating with me to move those agendas forward. Perhaps this research has created a slight paradigmatic shift among some participants to reconsider what they ignore in their daily transactions and negotiations in HCOs and the healthcare system. Our collaborations will hopefully include deeper considerations and understanding of power, knowledge, and ignorance dynamics to create a culture change in the healthcare sector.

In this chapter, I discuss the results of my study relative to the empirical literature and my theoretical framework. I suggest that NEs' identity and agency are heavily governed by the discursive and epistemic practices of both the HCOs within which they enact their role and the professional discourses underpinning nursing practice within the healthcare system. This chapter presents two main themes: (1) Identity and Boundary Management, where I discuss managing identity boundaries, identity and the neoliberal perspective, indicators and boundary management, and power, knowledge and ignorance; and the second theme, (2) Enacting Agency,

which includes how NEs enact moral, socio-professional, political, and epistemic agency. This chapter concludes with a discussion of the limitations of my research and the implications for nursing practice in administration, education and professional development, research, and policy.

6.1 Identity and Boundary Management

As discussed in Chapter 2, NEs' identity as nurses and executives is established early in their education and careers. CMS scholars, such as Alvesson and Wilmott (2002), have critiqued middle management, exploring the role of organizational discourses in regulating the identity of employees and managers. They contend that how one self-identifies is an active internally and externally constructed process:

> "We indicate how self-identity, as a repertoire of structured narrations, is sustained through identity work in which regulation is accomplished by selectively, but not necessarily reflectively, adopting practices and discourses that are more or less intentionally targeted at the 'insides' of employees, including managers." (Alvesson & Wilmott, 2002, p.627).

A CMS perspective labels management as not necessarily individual people but as a dominant ideology and neoliberal practice that shapes how institutions and people within them are governed (Alvesson et al., 2013). My study suggests that identity construction within organizations also occurs at the executive level, influenced by discourses circulating within healthcare organizations and the healthcare system. Hierarchies within the HCOs' executive team influence NEs, often compartmentalizing them within a strict and often reductionist clinical nursing frame. I speculate that omitting to extend critical analyses to all levels of organizational management and decision-making, including executive levels, can lead to overlooking important insights and nuances that distinctly shape, enable, and constrain executives across varying layers

of norms, power, and goals. Such oversight can perpetuate the assumption that the positionality of executives within the hierarchy of organizations puts them in a place of uncontested power and control over discourses, rules, and codes (McGoey, 2007).

In this study, we first see NEs' management of their identity in the context of the research interview. The study's interviews constituted an epistemic space where participants performed and chose which aspects of their identity to display and a discursive space where they enacted their moral, epistemic, political, and socio-professional agency.

Interestingly, however, other participants who did not know me before this study demonstrated similar complexity and depth in their responses. Having a shared knowledge of nursing in the homecare sector may have accounted for our ease of discussion during the interviews. This recognition from participants that a nurse was interviewing them was essential to this study as it influenced their discourse (Corbin & Morse, 2003; Croft et al., 2015; Sveningsson & Alvesson, 2003). For example, the participants often skipped over certain information if they thought I knew about specific nursing, homecare challenges, and healthcare system policies.

Participants mobilized discourses by carefully choosing which aspects of their identity to disclose, their perceptions, and how they defined and presented themselves as RNs during the interviews. Participants also carefully mobilized discourses by creating an image and identity of who they were as competent and knowledgeable RNs and how they navigated the complexities and intricacies of their role as NE. During the interviews, I observed that the participants seemed governed at times by how they believed I would perceive them or how I would portray their responses in this thesis. Some pointed out that interviews are confidential and voiced that there were potential professional risks to themselves, such as losing their credibility if they disclosed

negative information. For example, some participants' conversations reflected cautiousness when expressing satisfaction or dissatisfaction with their roles and responsibilities and their ability to manage daily transactions and negotiations. They often justified their HCOs' organizational trends, policies, and procedures.

By selecting which information to share during the interview, the participants appeared to reproduce a mode of functioning they adopt within the HCO, using the same processes to decide what to share or keep off-limits in doing so (Proctor & Schiebinger, 2008). Participants may have allowed themselves to say or not say certain things (to keep me ignorant of specific information), thus safeguarding their positionality in addition to my ethical management of the politics of their situations within the interview space (McGoey, 2007). My responsibility as a researcher, however, was to make the things that are unknown become known, to truth-tell (Morrow, 2005).

For these reasons, we cannot consider the interview space neutral; instead, it is subjective, epistemic, and political, displaying the power of the participants' and my respective socio-professional positionality. I discuss this further in the limitations section of this chapter.

6.1.1 Managing Identity Boundaries

Political science, sociology, anthropology, organizational studies, and healthcare scholars have researched boundary management (Ashforth et al., 2000; Chreim et al., 2013; Lamont & Molnár, 2002; May & Fleming, 1997; Weber et al., 2022). Boundaries have been conceptualized in various ways in the literature. For example, scholars have examined boundaries around individual and organizational identities (Czarniawska-Joerges, 1994; Kreiner et al., 2006). However, there is a dearth of literature on identity boundaries regarding NEs. For this discussion, I am focusing on identity boundaries as defined by Lile (2013), who speaks about boundaries as

mechanisms that allow one's identity to be preserved and evolve. Lile (2013) defines identity boundaries as:

> "a cognitive barrier that serves three functions: (a) it retains major elements of the identity by regulating the dissipation of identity content; (b) it distinguishes the ''me'' from the ''not me,'' or the ''self'' from ''other''; and (c) it regulates the impact of external identity options and social-cultural pressures that might threaten the cohesion of one's identity." (p.323)

Reshaping boundaries means both creating and breaking down boundaries. NEs become strategic in enacting their nursing values and maneuvering their identity between nurse and executive. Such an engagement in identity management and making choices about their actions shifts and disrupts their expectations. They attempt to have the time and space to reflect on discussions in meetings with others, to assess their emotions, and to consider their judgement about the practices around them. This study demonstrates that organizational boundaries established in HCOs both sustain and impede ignorance and knowledge in HCOs.

To support their business, HCOs often employ several executive actors specifically for their individual disciplinary and management knowledge. These executives can engage in boundary work concerning their identity, organizational positionality, knowledge, ignorance, and power. A collective discourse within HCOs is geared towards particular corporate goals, which influence how individual actors enact their agency and identity and which can work to reassess, temper, and discount previously held values and beliefs. (Alvesson & Willmott, 2002; Douglas, 1986). As a result, organizational memory becomes ingrained within the HCOs, creating an organizational environment that includes multiple objectives that only sometimes align but that the executive members must navigate (Alvesson et al., 2013; Chreim et al., 2013). Because the

dominant discourse inside HCOs concerns the fiscally constrained delivery of homecare services, challenges occur horizontally among executive members with varying personal and professional agendas. The executive realm, therefore, produces an image of exclusivity whereby NEs' executive identity includes them in that privileged space (Croft et al., 2015).

CNA and RNAO further perpetuate this imagery, telling NEs that they have influence, power, and authority due to membership in an executive team (CNA, 2009; RNAO, 2013; RNAO, 2011). However, the NEs also need to position themselves as experts in nursing and patient care, as this is their role and responsibility in the HCO. The NEs' identity as nurses creates a different image of a knower of nursing and patient care issues, which may exclude them from certain discussions and decisions. From a CMS perspective, this contrast in identity develops into a challenge for NEs as they need to fit the identity of the executive expected from and accepted by the other executives (Sveningsson & Alvesson, 2003). Therefore, their identity production and display depend on with whom they are in discussions. How NEs maneuver their identity within the social space of the HCO depends on their ability to be accepted by other executives. They tactically convey or momentarily cast aside their nursing or administrative identity to meet their agenda.

6.1.2 Identity and the Neoliberal Perspective

Policies and procedures set up by the provincial and national governments for the homecare sector create a neoliberal discourse that creates an organizational environment that selectively chooses which HCOs and homecare services they fund. The NE's identity is embedded in discourses from nursing associations that focus on publicly funded healthcare yet are working in private organizations that are considered contrary to that funding model for nursing (Lenartowych, 2014). The framing of HCOs within a neoliberal perspective, as discussed

in Chapter 2, politicizes homecare services and impacts NEs' identity as they question the viability of a publicly funded healthcare system (Labonté, 2020; Romanow, 2002).

For NE entrepreneurs leading their HCOs, we again see ignorance at play when they justify their HCO's pay-per-service model. My study shows that NEs who started their HCOs recreate some of the same power dynamics they claimed to escape in publicly funded nursing practice. The NEs ignore or attempt to work around the challenges faced by individuals and families who must pay for their HCOs' services. They talk about the importance of people having access to homecare services when they are not eligible for public-funded care. While those NEs might believe that all care should be publicly funded, they know that it differs from the current reality within a neoliberal healthcare frame (Stahlke Wall, 2015; Wall, 2014). Accepting this reality becomes a matter of economic survival for the NE entrepreneur, who must forego insights that challenge or question the ethical soundness of their corporate goals.

6.1.3 Indicators and Boundary Management

The provincial government excludes certain data, using a simplistic formula to address a complex healthcare sector. Specific indicators measure homecare services' efficiency and cost-effectiveness and drive organizational policies and procedures. Using specific indicators and fiscal calculations within a deterministic paradigm generates ignorance, making only specific knowledge known about homecare operations, effectiveness, challenges, risks and needs of people requiring care.

From a CMS perspective, this is key to creating a power dynamic that NEs must traverse. As discussed in Chapter 3, CMS, as informed by Foucault (1982), conceptualizes power as oppressive and productive, inseparable from knowledge, and dispersed throughout society. CMS scholars speak about power being used by organizations to produce stability and cohesiveness

(Alvesson et al., 2009). In this study, NEs exercise power by enrolling in thought and prioritization that make specific goals, such as profitability to the detriment of patient care, seem understandable and valuable (i.e., legitimate). They often position themselves as a central actor in developing community-based 'nursing-sensitive evidence-based indicators', thus influencing the chronicling of nursing in homecare (Backonja et al., 2022; Doran, 2011; White et al., 2022). By positioning themselves within these structures, NEs reiterate the primacy of existing assessment tools and make them work for nursing.

The SoI then helps to reveal that disregarding specific data ensures that what is not measured remains unknown. Consequently, disregarding specific data as a form of omission legitimizes the governments and HCOs' actions and further promotes the quantification of homecare nursing services (McGoey, 2007). The understanding of quality patient care is steered in a specific direction that does not necessarily reflect how NEs, as shown by the participants' narratives, identify a more holistic understanding of patient care (Lúanaigh & Hughes, 2016; White et al., 2022; Wong et al., 2013). This way of working becomes a productive mechanism within the HCO. As McGoey (2012b) discusses: "Declaring new resources unnecessary or irrelevant is fundamental to meeting targets or quotas beyond individual control. Ignorance can be the haven of personnel burdened by knowledge demands." (p.558)

While McGoey (2012b) is speaking about resource acquisition, this view of ignorance is relevant to using evidence-based indicators and data. The NEs are then immersed in a situation requiring reconsideration and questioning how the HCOs measure and deliver homecare services. They display intentionality in enacting agency and manifesting their identities as nurses and executives in these situations

Participants in this study believed that quantitative data gathered for the HCO and government provides only a partial picture of nursing services and patient care that the HCO provides, and that HCOs need to account for service fully. However, participants also identified that quality of care from a nursing perspective was only sometimes discussed and viewed favourably by other HCO executives. Participants felt comfortable questioning the risks of overconfidence in the tools and indicators with me, but they did not enjoy similar possibilities in their HCOs. From an SoI perspective, NEs may reinforce their nursing identity by using the tools and indicators to their advantage to ensure the provision of nursing homecare services to the best of their control. At the same time, they may reinforce their own identity as an executive within the HCO by conforming and, therefore, aligning their HCO favourably with government accountability mechanisms and ensuring the ongoing financial viability of their HCO.

These issues around identity and boundary management are closely connected. Managing one's own or someone else's knowledge and ignorance processes has implications regarding power dynamics in one direction or another. Individuals gain or lose strategic advantage in their daily transactions in HCOs.

6.1.4 Power/Knowledge and Ignorance

This study is essential to understanding how powerful groups engage in the deliberate construction of knowledge and ignorance. Knowledge and ignorance processes occur whereby NEs become strategic agents in how certain knowledge and discourses are deemed legitimate and dominant in HCOs and others less so. Knowledge circulates in HCOs and informs us about discourses that move horizontally, vertically and across healthcare sectors.

CMS is concerned with the role of dominant discourses and practices in organizations (Alvesson et al., 2013). More recently, Alvesson (2019) positioned leadership in "a broader

context of hierarchical and vertical divisions of work, labour processes and cultural and material pressures from various interest groups" (p. 38). As nurses and executives, the paradoxical position of NEs mediates their ability to access their nursing and organizational knowledge, act on nursing and organizational discourses, and use their power to influence HCOs and the healthcare system overall. NEs work to shift what organizational actors know, do not know, refuse to know, and need to know from their perspective.

As I discussed in Chapter 3, CMS highlights power structures within administration and ideological tensions between administrative narratives. From a CMS perspective, the social contexts within HCOs influence the NEs' identity construction (Alvesson & Wilmott, 2002). Thomas (2009) noted that power operates in organizations to "construct and stabilize identities" (p. 170). In this study, NEs enacted a choice when they sometimes downplayed their nurse identity and emphasized their "executive" or "business" identity. The actors in HCOs also create pockets of ignorance that can interrupt and amplify the flow of certain discourses. As discussed in Chapter 3, ignorance can be viewed as what is not known, cannot be known, or refused to be known in both positive and negative ways (McGoey, 2019). SoI for this study reveals the knowledge tensions by uncovering events that occur in HCOs to manifest ignorance, including suppression, unquestioned traditions, lack of memory, restrictive thinking, inattention, or deliberate or unintentional neglect (Bakonyi, 2018; McGoey, 2012a; McGoey, 2019; Perron & Rudge, 2016; Proctor & Schiebinger, 2008; Roberts, 2022; Townley, 2011).

This research exposes the distribution and transmission of knowledge, power, and ignorance within HCO's organizational cultures. From a CMS perspective, this study takes an analysis of the discourse beyond the focus of power imbalances and considers the manipulation of power by the NEs from an SoI perspective (Alvesson et al., 2013; Harvey et al., 2001;

McGoey, 2012b). It moves the dialogue to the social context of NEs in HCOs and the healthcare system. I examine this notion by problematizing the epistemic labour within HCOs that questions the configuration of the executive team's power, influence, and expertise. Epistemic labour may sometimes be apparent to the NE, and other times, it may be concealed. Because the flow of nursing knowledge is sometimes partially taken up, blocked, avoided, hidden, or denied through operational policies and procedures, the individual NE can become the visible faulty element of the HCO rather than the unresolved epistemic contradictions upon which it operates.

Participants' narratives demonstrate the multi-positionality of NEs. NEs are endowed with different expectations that are sometimes reconcilable and sometimes not. At the same time, they are expected to use their reasoning, resources, and problem-solving to promote and enforce nursing practice and competencies. As an object of power, knowledge, and certain discourses, NEs respond to the structures and cultural expectations within HCOs. However, NEs' narratives also demonstrate how they are subjects of power by influencing and mediating epistemic arrangements within HCOs (Foucault, 1982). They actively gear their motivations, priorities, and leadership toward HCOs' goals that they turn into their own.

From a CMS and SoI perspective, power movements at the executive level continually reorganize practices and policies, which can create new concerns, agendas, and priorities for NEs. As illustrated in my results, the selective choice of items on executive meetings' agenda strategically restricts discussions away from quality or flawed patient care challenges. Such omission often leads to the unopposed acceptance of how HCO services are traditionally delivered. As discussed in Chapter 3, selective and unintentional discounting or omission of information creates blind spots. In this study, we see knowledge and information that was invisible, or made invisible, whether purposeful or not, among the executive team about

improvements or changes needed in the delivery of patient care. These created areas of the HCO business that may have been overlooked, creating a lack of knowledge about certain aspects of homecare, and minimizing growth. This ultimately creates specific kinds of understanding about legitimate nursing leadership.

HCOs' claims to quality nursing care are predicated on a highly selective understanding of nursing care, a diminished version that appears to accommodate fiscal goals and profitability. More importantly, nursing knowledge and competencies are instrumentalized to meet these goals. NEs' knowledge of nursing and patient care is integral to the delivery and business of the HCO. The research findings show that NEs are employed by HCOs or lead HCOs precisely because of their professional nursing and management knowledge. However, NEs contend with other HCO executives' limited nursing and clinical care knowledge. This lack of knowledge by other executives is not intentional. However, it is still a form of ignorance. As the results expose, it is due to each executive's content-specific knowledge within their professional role in the HCO.

6.2. Enacting Agency

This section discusses how NEs enact their moral, socio-professional, political, and epistemic agency. As defined in Chapter 2, NEs' enacted agency, or how they act in the world, reflects the actions that they take to bring about their intended or desired change (Eteläpelto et al., 2013; López-Deflory et al., 2023). While I have separated various types of agency for discussion purposes, I know this may be oversimplifying or limiting. My findings show that NEs do not compartmentalize how they act. Instead, they consider events, issues, or decisions according to a multi-dimensional agentic frame where multiple types of agency interact and, often, build on one another.

6.2.1 Moral Agency

In this study, the nursing code of ethics partly informs NEs' moral agency or how they act ethically. Interestingly, a dearth of codes of ethics directs NEs' practice (Schick-Makaroff & Storch, 2019). The work by Schick-Manaroff & Storch (2019) highlights efforts to identify how codes of ethics can specifically inform nurse leaders' actions and practices. There have been some concerted efforts to articulate an ethical frame for nurse leaders' actions and decisions, with limited results. However, there is not necessarily a consensus on the extent to which there should be anything different for nurse leaders from an ethical practice compared to nurses at the point of care (Starzomski et al., 2023).

From a nursing perspective, one can reflexively assume that the NEs' moral imperative is tied explicitly to nurses' codes of ethics (Beagan & Ells, 2007). However, that assumption can be challenged from a CMS and SoI perspective. Moral agency cannot be summarized with a code of ethics since the code of ethics cannot reconcile the kinds of epistemic tensions identified in this study. Notwithstanding scholars Starzomski et al. (2023) and Rodney (2013) positions supporting codes of ethics, I suggest that we cannot limit the discussion on moral agency to codes of ethics, as they are narrow in informing nurses to navigate complex and challenging practice environments and situations. Codes of ethics centre on the notion of ethics as it relates strictly to patient interactions and often omit other areas of ethical engagement in nursing practice.

Scholars have examined nursing leadership's ethics and morality, focusing on individual leadership traits (Borawski, 1995; Hannah et al., 2005; Prestia et al., 2017). While moral agency has been explored in areas such as palliative care and private-duty nursing, the focus has been on nurses at the point of care (Morley & Sankary, 2023; Peter, 2002). My research highlights

contradictions where ethics is being instrumentalized to support business interests. I am uncertain whether this is specific to homecare or the executive level of nursing practice. Ethics in nursing needs to be framed differently for NEs to consider factors, such as healthcare as a commodity, that historically, nursing literature has not framed as necessarily ethical (Lenartowych, 2014). There is perhaps an implicit cooptation of ethical concepts that are subverted to support business interests and privately funded healthcare. In some respects, NEs emerge as moral agents, while at the same time, their discourse reflects the compromising what we traditionally consider ethical and moral in nursing. Therefore, some tensions are hard to reconcile. This raises the question of how NEs can uphold a more complete nursing moral agency.

Participants often evoked an ethical frame when discussing their experiences and the challenges of supporting the business interests of HCOs. They conveyed an ethical commitment to their nursing values and the values they place on their obligations as an executive in HCOs. There were moral and ethical undertones to the NEs' discourse and executive identity to achieve goals as an HCO executive. For example, some NEs were vocal in framing the need for safe, quality, ethical, and equitable patient care within their nursing ethics. While the discourse of equity can be seen as upholding nursing values, it also supports the business interests of HCOs (Dahlke & Stahlke Wall, 2017). As moral subjects, NEs are committed to dialectical relations with others, themselves, and through their actions (Bandura, 2002; Falk-Rafael, 2005; Liaschenko & Peter, 2016; Yarling, 1986). My research shows that NEs sometimes experience moral distress that results from living with the responsibilities of decisions that challenge their ethics and values as nurses (Ganz et al., 2015; Kortje, 2016). They are often conflicted by organizational and government demands, which make them feel constrained.

NEs are always enacting moral agency. However, there are instances, such as when they feel confined within the ethical dilemmas of maintaining the dominant discourse of the HCO that their moral agency is more visible (O'Connor, 2017; Prestia et al., 2017; Rodney, 2013). Scholars such as Starzomski et al. (2023) speak about how neoliberalism generates moral dilemmas that arise from the organizing ideological frame of healthcare systems and practices and how this frame conflicts with the values of NEs working in homecare. Starzomski et al.'s (2023) observation is echoed by other scholars (Hurley & Linsley, 2007; Schofield et al., 2011) and in my study whereby participants contended that people should receive care according to their needs. NEs are ethical subjects highlighted in the interviews through their desire for ethical practice and accessible care. Many NEs are morally distressed at their inability to change the dominant discourse within the HCOs, driving some of them to start their homecare businesses (Stahlke Wall, 2015; Tourangeau et al., 2014; Wall, 2014, 2015). For some participants, this was justified as an attempt to push back against ideals of privatization and profitability and to recenter nursing values onto patient care in the home. However, this may have intensified the pressures they sought to alleviate by creating new demands around competitiveness, economic viability, and fiscal accountability.

Guidance and normative documents can be helpful to NEs, but their usefulness is limited because they cannot reconcile the nonhomogeneous epistemic tensions that NEs experience. Consequently, for NEs, policymakers and regulators, there are risks for cooptation, instrumentalization and compromise of nursing ethics that need to consider the complete understanding of how organizations work, what ideologies they rest on, and the implications for the social context, clinical realm, people receiving care, and nurses. This has yet to be explored in the literature and needs further investigation. NEs need to understand the multidimensionality

of moral agency due to tensions arising from their different identities and the nature of their for-profit work, which influence what NEs want to accomplish in HCOs.

6.2.2 Socio-professional and Political Agency

As discussed in Chapter 2, socio-professional agency is the ability to act in spaces designed by and for professionals who belong to a regulated profession. NEs derive a certain status from that which shapes the type of agency that they embody in those spaces. One example of the participants' enacting socio-professional agency was illustrated in how they justified their commitment to nursing and their professional nursing identity by maintaining their RN license, framing this as personal pride. Participants' reliance on their nursing license attaches a notion of symbolism and mystique to this registration device. Their nursing license also serves as a form of legitimacy when working with other healthcare providers and nurses at the point of care. It communicates more than a license but something that the NEs deem very powerful in socio-professional and organizational spaces concerning their identity and the value they attach to their professional identity. They derive agency to justify their actions through their professional identity. Such standards provide structure and carry expectations of legal responsibility. I put forward that the NEs want to uphold their regulatory accountability and ethics as RNs.

NEs enacted their socio-professional agency by using their RN license as a tool to manage their identity as a nurse. As licensed RNs, the NEs are bound by the practice standards that inform them of their accountabilities to protect the public (College of Nurses of Ontario, 2022). NEs acquire nursing knowledge, mechanisms and procedures justified by legislation through the licencing body. Maintaining nursing credentials recognized within the healthcare field – such as an RN license - demonstrates the work the NE accomplished to become an RN. Whether or not having an RN license is mandatory for their position within the HCO, many NEs

insisted they saw this as necessary to be accepted by other NEs and to strategically manage those relationships.

NEs' socio-professional agency is closely related to the nursing values, norms, and standards they use to embody their identity as a nurse. They contend that their priorities are to deliver safe, quality patient care and organize the homecare nursing and clinical services accordingly. The NEs' education, socialization and professional development are drivers for their socio-professional agency, which allow them to exert a specific type of influence when they seek a more balanced approach to patient care and service delivery. However, the NEs' identity as nurses' ties closely with their identity as executives, where they have access to decision-making spaces where deliberate actions are taken. Political agency is then closely linked to this executive identity, demonstrating how these types of agency are closely intertwined and do not exist in silos.

As defined in Chapter 2, NEs' political agency is enacted when they engage within power structures to enact influence to promote social change (McMillan & Perron, 2020). Understanding political agency in scholarship is often limited to exerting leadership influence based on certain skills. A more critical conceptualization of political agency is needed. While using different terminology, Cutcliffe & Cleary (2015) challenge the current discourse in nursing leadership programs and guidance documents. Other scholars have called for a more critical politicized view of leadership in general (Collinson, 2011; Fast & Rankin, 2018; Learmonth & Morrell, 2017).

HCOs function as social machines with dominant discourses and practices that foster specific ways of thinking and acting for their members (McGoey, 2019). These become significant drivers in the expected roles of the executive team and how they make decisions to

support these goals. This limits what the executive team can bring to decision-making forums that work as a form of organizationally imposed restrictions on the skills and expertise of each executive. The NEs are subsequently immersed in a specific narrative that raises the question of how they can determine what they do not know. This causes broader questions about decision-making at the executive level in HCOs.

Societal, economic, and political issues have influenced NEs' positionality in HCOs. This study shows that social and political developments shaped NEs' political agency, influencing how other healthcare professionals, people receiving homecare, and the government might view them. My findings show that nursing leadership has a political dimension through collective and individual action. However, political agency is more than being politically active (Abrams, 1999; Krause, 2011; López-Deflory et al., 2021). It embodies the capacity to suggest change without being sure it will be effective.

When considering the theoretical framework grounding my study, the perspective of CMS can help us analyze NEs' enactment of their political agency through power relations within the hierarchical structures of the HCOs (Alvesson & Deetz, 2000; Alvesson & Willmott, 2002). These structures create the dominant discourse circulating in HCOs that overshadows nursing practice and patient care discourses. In turn, those structures produce an acceptance of the dominant discourse among the other executives. The findings of my study imply a dichotomy whereby the NEs enact their political agency by choosing when and how to challenge those power dynamics and assert their nursing knowledge to ensure quality patient care, uphold their role as executive team members, and maintain the HCOs' competitive advantage. As an executive team member, many NEs uphold the homecare brand by demonstrating their loyalty to the HCO. This way of working becomes a productive mechanism within the HCO.

Ignorance about nursing in HCOs and healthcare exists due to prior knowledge, entrenched assumptions and unawareness about nursing. Prevailing decision-making, governance, funding, clinical structures, and discourses are predicated on norms and traditions of what nursing is that are assumed to be legitimate. It does not occur to these individuals that their reading of this situation is predicated on an understanding limited by the historical exclusion of information that does not fit the dominant discourses that have historically shaped healthcare delivery. They selectively uptake nursing influence and knowledge towards achieving organizational goals. Socio-professional and political agency are tightly linked to epistemic agency. NEs enact their epistemic agency in organizational structures that assume that NEs already enjoy the status they should and need to function.

6.2.3 Epistemic Agency

Epistemic agency is the ability to act on knowledge, mobilize knowledge, and use knowledge to achieve certain outcomes, including (as seen earlier) exerting organizational influence (Elgin, 2013; Foucault, 1980; Lynch, 2013). Epistemic arrangements predetermine interactions between organizational agents whose status and influence hinge on their access to and strategic management of competing forms of knowledge (Reider, 2016). As discussed in earlier sections, NEs work to reshape knowledge and ignorance boundaries within the HCO to augment organizational knowledge to include the understanding of nursing and patient care. This challenge puts them in difficult positions in terms of epistemic versatility. While this gives them legitimate access to the other executives, they often downplay or conceal certain nursing knowledge in various forums to work around epistemic spaces that may call nursing knowledge into question.

Consequently, NEs do not have just one epistemic position; instead, they mobilize various knowledge registers to justify their decisions to make counterarguments (Beckstead & Beckstead, 2006). In this study, participants sometimes felt that they were put into positions by other executives where they were limited in what they knew, thought, or reacted to (Townley, 2011). These scenarios created different epistemic positions for the NEs depending on their access to knowledge. In effect, NEs are epistemic agents in ambiguous situations.

There is space within HCOs' infrastructures to accommodate the span of NEs' knowledge and expertise. Results indicate that NEs' epistemic agency in HCOs may be at risk due to a specific subset of their expertise used to do their work. Their epistemic positions overlap and create tensions where they are sometimes seen only as an executive with clinical nursing knowledge and expertise. Participants seemed to be aware of this as they engaged in various strategies to safeguard their epistemic legitimacy when there may be selective uptake of their knowledge. NEs developed strategies to navigate meetings without their legitimacy or credibility being problematized by the other executives. As participants described, when they feel the gap is too significant, it can generate discomfort, frustration, or distress. They may feel too much of a need to underutilize their nursing knowledge. Maintaining organizational legitimacy within the HCO is crucial to NE's epistemic agency.

When discussions move beyond the clinical realm of nursing and homecare, NEs work to neutralize the tension they experience. My findings show that NEs often live with epistemic tension when they have their knowledge questioned by executives in the HCO who are not nurses. The risks of organizational politics, wherein one's position may be externally determined, and only certain knowledge is valued, impact NEs' epistemic agency. If the dominant discourse, organizational cultures, or models of care in HCOs do not consistently draw on the NEs' broad

scope of knowledge, including nursing knowledge, the NEs' epistemic agency may become eroded. This wearing a way of NEs' epistemic agency can compromise their opportunity to promote and enforce nursing practice within the HCO, which can create and reproduce social processes within the HCO that may minimize nursing practice.

6.3 Limitations of the Study

In this study, participants were situated within the hierarchical social and epistemic positioning of nursing within HCOs, which, like all organizations, are not neutral. Consequently, when responding to my interview questions, the NEs may have framed their responses as appropriate based on their assumptions regarding my role as a nurse and researcher. As mentioned in the first part of this chapter, participants sometimes provided less information about homecare and nursing due to their knowledge about my experience as a community health nurse. Similarly, the NEs may have also been concerned about revealing information that might position them adversely in the eyes of others (e.g., me, other NEs, and others employed by HCOs) once this thesis is published. Therefore, social desirability and a desire to mitigate potential risks may have influenced their responses.

Another limitation was that I conducted interviews during participants' work hours at their request. A few participants were subsequently interrupted by phone calls and other activities around them. These interruptions may have prevented them from directing their full attention to the interview and contributing all of the information that they might otherwise have provided.

Maintaining confidentiality while working with a small, recognizable pool of participants was crucial to the study. It is prudent to be reminded that the number of NEs working in HCOs in Ontario is limited. The participants also network with one another through various nursing and healthcare forums external to the HCOs. Therefore, to protect participants' identities, I had to

carefully decide which data to include and which to leave out due to its potentially identifiable nature. Literature on practising as an ethical researcher (Corbin & Morse, 2003; Lee, 1995; Sampson et al., 2008) and my reflexivity as a community health nurse guided me in this decision-making process. I made some knowledge obtained through the participant's interviews accessible and other knowledge not available in this thesis (McGoey, 2012a). Protecting participants' confidentiality and identity exposed ignorance in authoring. Consider that if the definition of ignorance is considered, the selective omission of information is a form of ignorance. Though it was challenging to include all the quotes relevant to the research aim and questions, the need to protect the anonymity of all participants was ethically non-negotiable (Brackenridge, 1999; Lee & Renzetti, 1990). While specific quotes were illustrative, they were difficult to address in my thesis without putting participants or their HCO at risk of identification. Therefore, I only included some information in this thesis that I obtained through participant interviews and discussions with my thesis committee. My thesis advisor and thesis committee supported this approach.

The results of my study are specific to the province of Ontario, which may differ from other provinces and territories. While there are similarities in the roles and responsibilities of NEs in HCOs across provinces and perhaps elsewhere, realities and experiences differ. The study also focuses specifically on the homecare sector; therefore, caution should be exercised in contemplating the findings' relevance in other domains where NEs work.

A deeper exploration of the issues of gender, inequities, and race was beyond the scope of this research. My sample was not diverse, as all the NEs I interviewed were white women above 40. The lack of diversity in the sample of participants reflects the population of NEs in Ontario, pointing to the white hegemony of NEs in executive positions in general. The homogeneous

profiles of nurses predominantly occupying NE roles contrast with the diversity of the broader nursing community, including in homecare (Premji & Etowa, 2014). This enforces some forms of knowledge, power, and ignorance concerning how white supremacy is produced and maintained in HCOs. NEs in Ontario and Canada more generally need more diversity, and the current mix likely restricts the range of experiences captured in research.

The history of masculinity that has defined leaders and leadership and its relevancy to NEs was beyond the scope of this study. The participants' demographics in this study support the fact that NEs in HCOs are predominantly female. This participants of this study did not discuss HCO executive spaces as masculine spaces. Nevertheless, a few noted that the thought system in HCOs is based on traditionally masculine objectives and priorities due to the gendered history of homecare. Those participants discussed certain situations where it was difficult to engage in certain aspects of their experiences when engaging with other HCO executives.

In this study, participants did not necessarily connect their experiences to gender-based assumptions, inequities, or race. Among those participants who met with me a second time to discuss the subject of gender directly, I observed that they did not engage in those experiences and their broader implications. This may speak to the power dynamics of NE's identity construction process (Bardon et al., 2012). Perhaps these issues are so deeply ingrained in NEs' work that they have become invisible and taken for granted. I propose key areas for nursing practice and research in the following section on Implications for Nursing.

6.4 Implications for Nursing

At the outset of this thesis, I discussed the need for more research that has explored the discursive, epistemic, and power transactions in HCOs and the more extensive healthcare system that impacts NEs' enactment of their role and responsibilities. I also noted that nursing

knowledge needs to be developed to focus on the interaction between knowledge, power, and ignorance to better understand the organizational and systemic power relationships within which NEs are embedded. This section identifies the implications of my research for nurses, nursing, and leadership in the healthcare system. The study findings can contribute to scholarly knowledge about practice, education, policy, theory, and future research perspectives. My research can also enhance scholarship about leadership across healthcare and management disciplines by better understanding the power, knowledge, and ignorance dynamics within HCOs and the healthcare system.

6.4.1 Implications for Nursing Practice in Administration

From an administrative practice perspective, this study offers insightful applications for improving the practice of healthcare administration by highlighting the systemic and organizational interplay of knowledge, power, and ignorance in HCOs. Critical leadership studies have argued the need for more insight into leadership in daily nursing practices (de Kok et al., 2021). Much of nursing leadership scholarship is often dedicated to developing leadership strategies such as building relationships and enhancing personal communication skills to demonstrate the relevance of nursing (CCHL & CNA, 2023; Jones et al., 2016; Sundean et al., 2021).

Authoritative nursing association frameworks and guidance documents for NEs currently narrowly conceptualize knowledge and ignorance (CNA, 2009; RNAO, 2011; RNAO, 2013). Despite needing frameworks and guidance documents to support their work in these areas, NEs engage with relevant moral, socio-professional, political and epistemic challenges that confront them daily. While some nursing administration frameworks and guidance documents, such as those geared toward nurses in independent practice (Canadian Nurses Protective Society, 2023;

College of Nurses of Ontario, 2023b), include practice roles and responsibilities, the majority do not give voice to narratives highlighting power structures and the political dimensions of senior administrative roles. Experiences at the individual, organizational, and systemic levels need to be described, debated, and challenged. Documents that discuss NE roles and responsibilities also need to reflect multiple ways of understanding NEs' identity and agency.

As mentioned in the section on limitations of my study, further exploration in the literature about whiteness in nursing leadership to inform practice is needed. HCOs and healthcare settings more generally contribute to unequal power, knowledge and ignorance dynamics through overwhelming whiteness in NE leadership. Nursing researchers have identified that there is an underrepresentation of minorities in nursing in Canada (Covell et al., 2017; Jefferies et al., 2019; Vukic et al., 2016). However, organizations have been slow to incorporate strategies to fix the underrepresentation of diverse populations. HCOs and nursing associations must create policies that promote cultural, racial and gender diversity in the workplace and eliminate discriminatory selection and hiring processes (Covell et al., 2017; Etowa & Debs-Ivall, 2017). In addition to policy changes, Etowa & Debs-Ivall (2017) propose that commitment from healthcare organization leadership, changes in organizational culture and supporting resources are needed to effect any substantial change. The lack of organizational cultural change, with some populations being overrepresented, reflects the function of power, agency and ignorance in particular ways.

6.4.2 Implications for Education and Professional Development

I define education as undergraduate and graduate nursing programs, continuing education, and professional leadership programs (e.g. nursing leadership). Using the theoretical

frameworks of CMS and SoI, my study revealed shortcomings and gaps in those programs. For example, this study has demonstrated the need for content that addresses:

1) Power circulation in healthcare organizations and across the healthcare system.

2) Nursing identity management, including at higher administration levels.

3) How nurses in leadership roles enact their agency, identity, values, and means in healthcare.

The theoretical contribution of this study combines nursing disciplinary knowledge with a sociological and management viewpoint, which can enhance nursing education and professional development. Similarly, paying particular attention to epistemic agency provides new perspectives on traditional nursing leadership literature and, therefore, can be used by educators as a core concept in nursing education. It can enhance disciplinary knowledge by better understanding the power, knowledge, and non-knowledge (ignorance) relationships within healthcare organizations.

Knowledge is contextual, and the nursing discipline needs to expand how it defines ways of knowing. From a pragmatic perspective, the maintenance of a blind spot in nursing education is demonstrated in the lack of business courses in schools of nursing. While this education gap may be due to a lack of awareness, it can also be interpreted as an intentional strategy within schools of nursing to perhaps reinforce the interpretation of nursing as a clinical profession.

Understanding what knowledge is legitimized and taken for granted by broadening the conceptual and theoretical thinking of nurses (including nurses in senior leadership roles) as epistemic agents would add a new, critical dimension to nursing leadership scholarship. I hope this will change the current landscape of attrition and withdrawal by student nurses, nurses at the point of care, and nurses in leadership and management positions. Similarly, leadership and

continuing education programs must include considerations around healthcare settings as epistemic spaces.

Professional development leadership programs currently create an articulated or modular vision of leadership. Most, if not all, are situated within a post-positivist paradigm. While the language used in these programs focuses on inward and outward-facing competencies (e.g., emotional intelligence), these teach NEs about reflecting on their gaps. Leadership training programs need to move beyond assumptions of individual competency toward a clearer understanding of NEs within complex social structures. Current leadership training programs subject NEs to various ideological processes that can simultaneously enable, dictate, neutralize, or skew their ability to access or act on their knowledge (CCHL & CNA, 2023; RNAO, 2013).

Professional leadership programs often focus on conflict management rather than delving into ideological conflicts that may not be possible to reconcile. These programs are typically predicated on the notion that executives are responsible for smoothing over tensions and conflicts to move the organization's agenda forward, with little attention to their deeply ontological and epistemological nature. This results in an idealized, apolitical reading of the complex nature of healthcare and NE management work. It assumes that NEs can manage such tension straightforwardly with the proper skill set and techniques. This stunts the more profound, philosophical, and reflexive dispositions critically needed to confront complex realities of NEs' work that Schön (1983, p.67) describes as "a swampy lowland[s] where situations are confusing 'messes' incapable of technical solutions." Ignoring these complexities in leadership education and professional development is in and of itself an act of ignorance, and it sets NEs up for failure, or at minimum, puts them at high risk of moral distress when they are left to navigate these complexities with no formal education or awareness of their existence.

Professional leadership development programs set up a specific, pragmatic discourse on how NEs (should) think about healthcare and how to work as an NE (Hannah et al., 2014). They situate the NEs as actors expected by their CEO, Board, and nursing associations to do what is expected of them, often dictated by others, including provincial governments. They overlook the challenges, tensions, and sometimes distress that NEs experience in unforgiving healthcare environments. NEs often conclude that they lack the skills to manage challenging situations (Crawford et al., 2017; Malloch & Melnyk, 2013).

6.4.3 Implications for Research

An important shift in the governance of the homecare sector changed the power and authority structure within HCOs (Grypma et al., 2012). The corporatization of homecare services is governed and regulated by the government within a non-nursing frame, which often restricts NEs. I question the impact of the current organizational and governance structures on NEs' identity and agency. Nurses need to research the historical ignorance at play in HCOs. My research shows that the critical political reading of NEs' influence and participation in power relationships in HCOs still needs to be improved in nursing literature. Studies are needed that explain the social influences that demonstrate NEs' enactment of agency.

Feminist inquiry is needed to clarify the gendered role dynamics and patterns of epistemic legitimacy along gendered lines in HCOs. As discussed previously, participants talked about the benefits of telling stories while underscoring the risks of speaking about feelings. Their focus was often on statistics, data and key performance indicators to create a compelling way to get other executives' buy-in. These strategies worked sometimes and not others, and further inquiry is needed to delineate how gender dynamics mediated successes or failures. Nursing

researchers must pay attention to gender dynamics as they play out in HCOs, making explicit links to a feminist lens.

Understanding the discourses, assumptions and ideologies that shaped the production, obligations, and legitimization of norms and how they impact NEs' identity and agency are essential to understanding the cultural shift that needs to occur in nursing and the healthcare system to preserve NEs' well-being and to allow them to maximize their influence. Research that delves into the complex experiences of NEs needs to be changed. My study has started the foundation for a critical research program on NEs. As I stated in Chapter 2, research on NEs often situates them in acute care settings, concentrating on leadership competencies, behaviours, and attributes that overlook the exploration of discursive, epistemic, and power transactions occurring at the executive levels of HCOs and other practice domains.

CMS and SoI as theoretical frameworks can uniquely contribute to such nursing scholarship (Ashley & Perron, 2023). Nursing, healthcare, and healthcare management scholarship have used and re-used many of the same models and frameworks over the past few decades (Alvesson, 2019). However, substantial issues remain in deploying the insights needed for a paradigm shift in nursing, nursing and healthcare leadership programs, and health policy. More critical perspectives on those issues are needed. This is consistent with calls for critical analysis from critical management and critical leadership scholars (Alvesson, 2020; Collinson, 2011; Hutchinson & Jackson, 2013; de Kok et al., 2023). Scholars and researchers must better engage with more critical and political analyses of management, leadership, and related phenomena to revitalize the field. Fresh insights can be brought forth from the perspectives of CMS and SoI.

Using Fairclough's CDA (2013) was a way to expose how the subject positioning of NEs is constructed discursively. My study exposed organizational knowledge and ignorance dynamics that remain largely concealed and unchallenged yet are integral to understanding NEs' socio-professional and political positionality. A critical research approach such as Fairclough's CDA (2013) can contribute to research to unravel everyday discourse and discursive practices in nursing.

6.4.4 Implications for Policy

Over the past two decades, professional associations for nurses and other healthcare providers have developed policies, conducted public and stakeholder consultations, and met with government officials to advocate for more effective and accessible homecare services in Ontario and Canada (CHCA, 2017; Romanow, 2002; Lefebre et al., 2020; Sharkey et al., 2003). Recently, provincial government officials directed their narratives toward improving homecare (Ontario, 2022). Despite these efforts, little change has occurred. My study provides a new way of considering policy and generating support for future policy initiatives. An analysis that explores the historical ignorance at play in the development and implementation of health policy would expose narratives that have yet to garner attention. Identifying ignorance wilfully or unconsciously used by government officials and policymakers is a strategy that can be used by nurses and NEs advocating for improved homecare (McGoey, 2019).

Chapter 7: Conclusion

This research started with my interest in understanding why some NEs flourish and others struggle in their positions in HCOs. It seemed counterintuitive that nurses in the highest nursing position in a healthcare organization would be labouring to achieve their goals. Using critical discourse analysis and an original theoretical framework, I took this research from a post-positivist approach traditionally used in nursing leadership to a less recognized critical theory approach. My research explored how NEs enact their moral, socio-professional, political, and epistemic agency in HCOs.

The contribution of my theoretical framework of CMS and SoI provides a new understanding of knowledge, power, and ignorance relationships within which NEs are embedded. This framework departs from traditional nursing leadership scholarship. The discourse permeating healthcare about promoting interdisciplinary practice must go beyond the practice domain into research and education. Incorporating a sociological viewpoint of NEs as epistemic agents into nursing leadership scholarship is disruptive. As stated by Ashley & Perron (2023):

> "CMS and the SoI set a different understanding of HCOs as epistemic landscapes, exposing institutional knowledge and ignorance dynamics that remain largely concealed and unchallenged yet are integral to understanding NEs' epistemic agency." (p.7)

My research shows that NEs are immersed in dominant neoliberal discourses and practices in HCOs, distinct epistemic landscapes that maintain specific power arrangements. It highlights NEs' epistemic positioning, which depends on their access to and awareness of what is occurring, the rationale for decisions, and their access to forums, allowing them to share their expertise. NEs enact epistemic versatility by balancing boundaries imposed by others and

themselves, working to create spheres of discourse and influence. They both interrupt and amplify the flow of knowledge and ignorance in HCOs to secure their epistemic legitimacy in HCOs. However, nurses rarely use these concepts when speaking about nursing leadership.

This study calls into question the extent to which the expectations of nurse leaders to be fully informed about their leadership are realistic. Nursing and healthcare leadership education and professional development programs and guidance documents continue to situate NEs as analytical people with specific skills, behaviours, and attributes to solve problems but avoid discussions that tackle experiential and philosophical questions. As long as these programs and documents remain unchanged, nurses will struggle with their epistemic legitimacy within the healthcare system. Nursing and healthcare leadership education and professional development programs must engage with critical perspectives to discuss relational and epistemic issues that govern the daily lives and work arrangements of NEs. Nurses must understand the epistemic practices within HCOs and healthcare more broadly to recognize the knowledge, power, and ignorance dynamics that underlie the healthcare system. Critically reflecting on contemporary discursive registers within epistemic spaces can help disrupt problematic norms, assumptions and expectations about NEs held by various actors within healthcare systems, including NEs themselves.

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Appendix A: Licensing Agreement for Reprint of Article for Chapter 3

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		Expected Presentation Date	2023-09-29
Instructor Name	dr. amelie perron		

ADDITIONAL DETAILS

Appendix B: Research Subject Log

Research Subject Log

Participant's Code	Gender	Date of recruitment (consent signed and received)			Date of Interview			Age	# Positions held as NE		# years as NE	Highest level education		Certification		Licence (RN)	Current Role
		dd	mm	yy	dd	mm	yy		Other	HC		Nursing	Other	Nursing	Other		

Appendix C: Study Information Sheet and Consent Form English

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Information Sheet and Consent Form

Principal Investigator:
Lisa Ashley, RN, MEd, PhD (c), CCHN(C)
School of Nursing
Faculty of Health Sciences
University of Ottawa

Supervisor :
Amélie Perron, RN, PhD
Associate Professor
School of Nursing
Faculty of Health Sciences
University of Ottawa

Title: Organizational Agents as Epistemic Agents: Re-examining Nurse Executives' Agency in Homecare Organizations

Invitation to participate

You are invited to participate in the above-mentioned doctoral thesis project conducted by myself, Lisa Ashley, a doctoral candidate enrolled in the School of Nursing doctoral program, and my thesis supervisor, Dr. Amélie Perron. Participants for this research are the highest administrative level of nurse in a home healthcare organization in Ontario, responsible for all nursing services as well as administrative and/or operational responsibilities. You may be currently working, be retired, or have previously worked in such position. You are currently or have previously been licensed as an RN. You are able to respond to the interview in English.

Why is the study being done?

The purpose of this doctoral research is to learn more about the role and experiences of nurse executives in the home healthcare context in Ontario, a subset of nurses about whom very little research is done. Topics that will be discussed in the interview will include but will not be limited to your roles and responsibilities, challenges that you may experience or have experienced, facilitators or misunderstandings about your role and the extent to which you feel able to fulfil your role and responsibilities.

How many people will take part in this study?

20 nurse executives will take part in this study.

Nature of your participation

Your participation will consist of one private interview with the principal investigator, Lisa Ashley. During this interview you will be asked to discuss your experiences as a nurse executive. The interview will be done over a secure virtual platform (Microsoft Teams), or the phone and it is expected to last between 45 and 90 minutes depending on your availability. It will be held in a confidential location agreed upon by you and the principal investigator. It will be digitally recorded unless you decline (in which case hand-written notes will be taken). You will also be asked to fill out a short socio-demographic questionnaire (2 minutes).

The recorded interview will be transcribed by the principal investigator, after which the audio file will be kept for 7 years. All identifying information mentioned during the interview (e.g., names of executives, managers, staff, organizations, cities, etc.) will be eliminated from the transcript. A random code will be used instead of your name on your transcript and socio-demographic questionnaire.

What are the risks of participating in this study?

You may find it emotionally difficult to discuss some of your experiences with regards to your role as a nurse executive. You are free to decline to answer any questions; you may ask that the recorder be turned off or to put a stop to the interview at any time. You are expected to share only the information you are comfortable disclosing. Should you feel distressed you can stop the interview and the researcher can assist you in contacting your employee assistance program should you express this wish. All the information you provide will be confidential and de-identified.

What are the benefits of participating in this study?

Your participation will not have a direct benefit to you. However, it will give you an opportunity to express your opinion about the role of nurse executives in home healthcare organizations. It will also serve to raise awareness about nurse executives' experiences.

What about Confidentiality and Privacy?

The information you share will remain strictly confidential. It will only be used for the purpose of this study. Access to the research data will be limited to the principal investigator and her thesis supervisor. A random code will be used to identify your interview transcript and questionnaire. By participating in an online or telephone interview, someone around you may overhear what you are saying. It is therefore important that you plan well for the interview in a place that provides you with a maximum of privacy. During the transcription of the interview, all names mentioned in the course of the interview (persons, organizations, cities, etc.) will be eliminated, as well as any information that could identify a current or former employer (e.g. organizational events such as a merger, etc.). The research data (audio recordings, consent forms, interview transcripts, socio-demographic questionnaire) will be securely stored in a locked filing cabinet in Ms. Ashley's locked private home office, after which time the data will be transferred to Dr. Perron's locked private office at the University of Ottawa. The research data will be kept for 7 years, until June 2028. After this time, all data will be destroyed and shredded.

Dissemination of the results

You will be provided with a summary of the results at the conclusion of the study. Results will be published in scientific journals and will be presented at conferences. Results may also serve as teaching material for a research or leadership course. In all cases, you and your employers will never be identified. When needed, the random code you were assigned will be used.

If I wish, how would I withdraw from the study?

You are under no obligation to participate in this study. You may withdraw from the study at any time without justifying your decision. All of your paper and digital research data (e.g. consent form, interview audio file and transcript, socio-demographic questionnaire, field notes, e-mails) will be destroyed and shredded. Your signature on this form indicates that you understand the information regarding this study and that you agree to participate. By signing this form, you are not waiving your legal rights as a research participant nor are you releasing the investigators from their legal and professional responsibilities.

Ethical aspects of this study

You may contact the principal investigator or her supervisor at any time regarding this study and your participation. This doctoral thesis study received ethics approval from the University of Ottawa Research Ethics Board. Any question or concern about the ethical conduct of this study may be addressed to the Protocol Officer for Ethics in Research at the University of Ottawa, Tabaret Hall, room 154, 550 Cumberland St., Ottawa, ON, K1N 6N5. Phone: (613) 562.5387; Email: ethics@uottawa.ca.

Consent

I, _____ (name in print), have read and understood this consent form. All my questions and concerns were addressed to my satisfaction. I may contact the investigators of the study at any time for further information.

I accept to have my interview digitally recorded: Yes ☐ No ☐
I accept to be quoted directly (any identifying information will be removed): Yes ☐ No ☐

Correspondence may be directed to: Lisa Ashley
I agree to participate in this study. There are 2 copies of this consent form, one of which is mine to keep.

Participants signature: _____

Principal Investigators signature: _____

Date: _____

Appendix D: Study Information sheet and Consent Form French

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Lettre d'information et formulaire de consentement

Chercheuse principale :
Lisa Ashley, IA, ICSC(C), M. Éd., Ph.D.(c)
Candidate au doctorat et chercheuse principale
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Superviseur :
Amélie Perron, IA, PhD
Professeure agrégée
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Titre du projet : Les agents organisationnels en tant qu'agents épistémiques: Repenser l'agence des infirmières et infirmiers cadres dans les organisations de soins à domicile

Invitation à participer

Vous êtes invité(e) à participer au projet de thèse de doctorat susmentionné mené par moi-même, Lisa Ashley, candidate au programme de doctorat de l'École des sciences infirmières, et ma directrice de thèse, Dre Amélie Perron. Les participant(e)s à cette recherche sont des infirmières ou infirmiers au plus haut niveau administratif d'un organisme de soins à domicile en Ontario, en charge de toutes les services infirmiers ainsi que des responsabilités administratives et opérationnelles. Vous pouvez être actuellement en activité, à la retraite ou avoir déjà occupé un tel poste. Vous êtes actuellement ou avez déjà été titulaire d'une licence d'infirmière ou d'infirmier autorisé. Vous êtes en mesure de répondre à l'entretien en anglais.

Pourquoi cette étude est-elle réalisée ?

L'objectif de cette recherche doctorale est d'en apprendre davantage sur le rôle et les expériences des cadres infirmiers dans le contexte des soins à domicile en Ontario, un sous-groupe infirmier à propos desquels très peu de recherches sont menées. Les sujets qui seront abordés lors de l'entretien porteront notamment sur vos rôles et responsabilités, les défis que vous pouvez rencontrer ou vousavez rencontrés, les facilitateurs ou les malentendus concernant votre rôle et dans quelle mesure vous vous sentez capable de remplir votre rôle et vos responsabilités.

Combien de personnes participeront à cette étude ?

Vingt cadres infirmiers participeront à cette étude.

Nature de votre participation

Votre participation consistera en un entretien privé avec la chercheuse principale, Lisa Ashley. Aucours de cet entretien, il vous sera demandé de parler de vos expériences en tant que cadre infirmier. L'entretien se déroulera sur une plateforme virtuelle sécurisée (Microsoft Teams) ou partéléphone et devrait durer entre 45 et 90 minutes selon votre disponibilité. Il se déroulera dans un lieu confidentiel convenu entre vous et la chercheuse principale. L'entretien sera enregistré numériquement, à moins que vous ne refusiez (dans ce cas des notes manuscrites seront prises). Vous devrez également remplir un court questionnaire sociodémographique (2 minutes).

L'entretien enregistré sera transcrit par la chercheuse principale, après quoi le fichier audio sera conservé pendant une période de 7 ans. Toutes les informations pouvant vous identifier (ex : nomsde hauts administrateurs, gestionnaires, membres du personnel, organisations, villes, etc.) seront éliminées de la transcription. Un code au hasard sera utilisé au lieu de votre nom sur votre transcription et votre questionnaire sociodémographique.

Quels sont les risques liés à la participation à cette étude ?

Vous pouvez trouver difficile, sur le plan émotionnel, de discuter de certaines de vos expériences relatives à votre rôle de cadre infirmier. Vous êtes libre de refuser de répondre à toute question ; vous pouvez demander que l'enregistreur soit éteint ou que l'entretien soit interrompu à tout moment. Il est attendu que vous ne communiquerez que les informations que vous êtes à l'aise de divulguer. Si vous vous sentez en détresse, vous pouvez interrompre l'entretien et la chercheuse pourra vous aider à contacter votre programme d'aide aux employés si vous en manifestez le désir. Toutes les informations que vous fournirez seront confidentielles et dépersonnalisées.

Quels sont les avantages à participer à cette étude ?

Il n'y a aucun avantage direct à participer à ce projet. Toutefois, en y participant vous aurez l'occasion d'exprimer votre opinion sur le rôle des cadres infirmiers dans les organismes de soins à domicile. Elle servira également à sensibiliser les gens aux expériences des cadres infirmiers.

Qu'en est-il de la confidentialité et de la vie privée ?

Toutes les informations que vous partagez demeureront strictement confidentielles. Elles ne serontutilisées que dans le cadre de cette étude. L'accès aux données de recherche sera limité à la chercheuse principale et à sa directrice de thèse. Un code aléatoire sera utilisé pour identifier votretranscription d'entretien et votre questionnaire. En participant à un entretien en ligne ou par téléphone, il se peut que quelqu'un de votre entourage entende ce que vous dites. Il est donc important de bien planifier l'entretien dans un lieu qui vous assure un maximum d'intimité. Lors de la transcription de l'entretien, tous les noms mentionnés au cours de l'entretien (personnes, organisations, villes, etc.) seront éliminés, ainsi que toute information pouvant permettre d'identifier un employeur présent ou passé (par exemple, des événements organisationnels tels qu'une fusion, etc.). Les données de recherche (enregistrements audio, formulaires de consentement, transcriptions d'entretiens, questionnaire sociodémographique) seront conservées en toute sécurité dans un classeur verrouillé dans le bureau privé de Lisa Ashley à son domicile. Les données de recherche seront conservées pendant 7 ans, jusqu'en juin 2028. Après cette période,toutes les données seront détruites et déchiquetées.

Diffusion des résultats

Un résumé des résultats vous sera fourni à la fin de l'étude. Les résultats seront publiés dans des revues scientifiques et seront présentés lors de conférences. Les résultats peuvent également servirde matériel pédagogique pour un cours de recherche ou de leadership. Dans tous les cas, vous et vos employeurs ne serez jamais identifiés. Lorsque nécessaire, le code aléatoire qui vous a été attribué sera utilisé.

Si je le désire, comment pourrais-je me retirer de l'étude ?

Il n'y a aucune obligation pour vous de participer à cette étude. Vous pouvez vous retirer de l'étude à tout moment sans avoir à justifier votre décision. Toutes vos données de recherche sur papier et sur support numérique (ex : formulaire de consentement, transcription d'entretien, questionnaire sociodémographique, notes de terrain, courriels) seront détruites et déchiquetées. Votre signaturesur ce formulaire indique que vous comprenez les informations relatives à cette étude et que vousacceptez d'y participer. En signant ce formulaire, vous ne renoncez pas à vos droits légaux en tant que participant à la recherche ni ne libérez les chercheuses de leurs responsabilités légales et professionnelles.

Aspects éthiques de cette étude

Vous pouvez contacter la chercheuse principale ou sa directrice de thèse à tout moment concernant cette étude et votre participation. Cette recherche doctorale a reçu l'approbation éthique du Comité d'éthique de la recherche de l'Université d'Ottawa. Toute question ou préoccupation concernant laconduite éthique de cette étude peut être adressée au Responsable du protocole pour l'éthique de la recherche à l'Université d'Ottawa, Tabaret Hall, salle 154, 550 Cumberland St., Ottawa, ON, K1N 6N5. Téléphone : (613) 562.5387 ; Courriel : ethics@uottawa.ca.

Consentement

Je,_____(nom en lettres moulées), ai lu et compris ce formulaire de consentement. Toutes mes questions et préoccupations ont été traitées à ma satisfaction. Je peux contacter les chercheuses à tout moment pour de plus amples informations.

J'accepte que mon entretien soit enregistré numériquement : oui □ non □

J'accepte d'être cité directement (tout information identifiante sera supprimée) : oui □ non □

Si vous avez des questions ou des préoccupations au sujet de cette étude, vous pouvez contacter: Lisa Ashley

J'accepte de participer à cette étude. Une copie du formulaire de consentement vous sera laissée etune copie sera conservée par l'équipe de recherche.

Signature – Participant(e) : _____

Signature - Chercheuse principale : _____

Date : _____

Appendix E: Recruitment Letter to Organizations

Date [name of organization's executive director, chief executive officer or president]:

This letter is a request for ***[name of organization]***'s assistance to invite registered nurses to participate in research I am conducting as part of my Doctoral degree in the School of Nursing at the University of Ottawa, under the supervision of Dr. Amélie Perron**.** The title of my research is "Organizational Agents as Epistemic Agents: Re-examining Nurse Executives' Agency in Homecare Organizations". The purpose of this research is to learn more about the role and experiences of nurse executives in the home healthcare context in Ontario, a subset of nurses about whom very little research is done. The attached Information Sheet and Consent Form provides you with further details about the research which has received ethics approval from the University of Ottawa.

It is my hope to recruit participants for this research through your organization. I have attached a Recruitment Social Media Script in English and French that can be posted on your ***[name of social media used by organization i.e., Instagram, Twitter and LinkedIn accounts, your email listserv, and your Facebook Account].*** All interviews will be conducted in English. I believe that your members have unique understandings and stories related to their roles and responsibilities that will serve to raise awareness about nurse executives' experiences.

If you have any questions regarding this study or would like additional information, please contact me. You may also contact my supervisor, Dr. Amélie Perron.

I hope that the results of my study will be beneficial to the ***[name of organization]***, as well as the broader nursing and healthcare community. I look forward to speaking with you and thank you in advance for your assistance with this project.

Yours sincerely,

Lisa Ashley, RN, MEd, PhD (c), CCHN(C)School of Nursing

Faculty of Health SciencesUniversity of Ottawa

Appendix F: Social Media Recruitment Ad English

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Nurse executives' experiences in home healthcare organizations in Ontario

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Current or former nurse executives in home care are invited to participate in a study:

Who hold or have held the highest-level nursing position in a home healthcare organization in Ontario
AND

Are or were responsible for administrative and operational nursing services
AND

Are comfortable sharing their experiences in English in a private interview

This research forms part of Lisa Ashley's doctoral studies in Nursing, under the supervision of Dr. AméliePerron, RN, PhD. It is being conducted to better understand nurse executives' experiences in the home care context as well as identify the supports and challenges they face.

The study involves a private interview (45 to 90 minutes long, depending on participants' availability) and filling out a short sociodemographic questionnaire (2 minutes). Participants' information as well as their current or former place of work will be kept strictly confidential. Only Ms. Ashley and her thesis advisor willhave access to the research data.

Participants who are eligible will be recruited on a first come first served basis. In the event that more than 20 participants express interest in the research, those not selected will be informed by email that they havenot been included.
This study received ethics approval from the University of Ottawa's Research Ethics Board.

For more information, please contact:
Lisa Ashley, RN, MEd, PhD (c), CCHN (C)
Doctoral Candidate and Principal InvestigatorSchool of Nursing
Faculty of Health SciencesUniversity of Ottawa

Appendix G: Social Media Recruitment Ad Ffrench

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L'expérience des cadres infirmiers dans les organismes de soins à domicile en Ontario

---

Les infirmières et infirmier cadres actuelles ou anciennes en soins à domicile sont invitees à participer à la recherche :

Qui occupent ou ont occupé le plus haut poste d'infirmière dans un organisme de soins à domicile en Ontario
ET
Sont ou étaient responsables des services administratifs et opérationnels de soins infirmieres
ET
sont à l'aise pour partager leurs expériences en anglaise

Cette recherche s'inscrit dans le cadre des études doctorales de Lisa Ashley en sciences infirmières, sous la direction du Dre Amélie Perron, Inf, PhD. Elle est menée pour mieux comprendre les expériences des cadres infirmiers dans le contexte des soins à domicile ainsi que les soutiens et les défis auxquels ils sont confrontés.

L'étude comprend une entrevue privée (d'une durée de 45 à 90 minutes, selon la disponibilité des participants) et le remplissage d'un court questionnaire sociodémographique (2 minutes). Les informations concernant les participants ainsi que leur lieu de travail actuel ou précédent seront strictement confidentielles. Seules Lisa Ashley et son superviseur de thèse auront accès aux données de la recherche.

Les participants éligibles seront pris en compte selon le principe du premier arrivé, premier servi. Dans le cas où plus de 20 participants exprimeraient leur intérêt pour la recherche, ceux qui ne seront pas sélectionnés seront informés par courrier électronique qu'ils n'ont pas été inclus.

Cette étude a reçu l'approbation éthique du Comité d'éthique de la recherche de l'Université d'Ottawa.

Pour plus d'informations, veuillez communiquer avec :

Lisa Ashley, inf. aut., ICSC(C), MÉd, PhD (c)
Candidate au doctorat et chercheur principale
École des sciences infirmières
Faculté des sciences de la santé
Université d'Ottawa

Appendix H: Documents Analyzed

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Registered Nurses' Association of Ontario [RNAO]. (2011). *CNE/CNO Governance and Leadership Initiative Role Description Framework, RNAO – Registered Nurses' Association of Ontario*. https://rnao.ca/sites/rnao-ca/files/CNE_CNO_roles_and_responsibilities_framework_-_July_2012.pdf

Wakefield, M., Williams, D. R., & Le Menestrel, S. (2021). *The future of nursing 2020-2030: Charting a path to achieve health equity*. *Chapter 9: Nurses Leading Change pp. 275-*

300. National Academy of Sciences. https://doi.org/10.17226/25982. Chapter 9: Nurses Leading Change pp. 275-300.

Appendix I: Socio-Demographic Questionnaire

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Socio-Demographic Questionnaire

You are free to decline to answer any questions, or to stop your participation in this study at any time. You should only share the information you feel comfortable disclosing.

Participant ID:
Date & Time of interview:
Age:
Sex/gender:
First language:
Race/ethnicity:

- ☐ Caucasian
- ☐ First Nations, Métis or Inuit
- ☐ Black (incl. Caribbean and African origin)
- ☐ Latin American
- ☐ Asian (incl. West Asian, East Asian and Southeast Asian origin) or Pacific Islander
- ☐ Middle Eastern or North African
- ☐ Other – please specify:_____

What is your current occupational title?
How many positions as nurse executive have you held?
In homecare: _____
In other contexts (e.g. public health, tertiary care, etc.): _____
How long (months, years) have you (were you) in a nurse executive position in homecare? ____
How many years of practice in nursing do you have? _____
What is your highest level of education?

- ☐ Undergraduate
- ☐ Graduate degree in nursing
- ☐ Graduate degree (other) Please specify:

What certifications do you have? _____
What license do you currently hold?

- ☐ RN
- ☐ RPN
- ☐ Other (Please specify):
- ☐ None

Appendix J: Additional Interview Questions

1. What strategies, if any, did you use to make government understand the importance of homecare?
2. How did you represent and identify yourself? Did 'nurse' in your title, or your nursing background ever become a liability or a risk? Why, or why not?
3. How did gender dynamics affect your role as nurse executive? In the organization and with others, such as government.

Appendix K: Participant Interview Guide

Thank you for agreeing to participate in this interview. The purpose of this research is to learn more about the role of nurse executives in the home healthcare context in Ontario. Topics that will be discussed in the interview will include but will not be limited to your roles and responsibilities, challenges that you may be experiencing, facilitators or misunderstandings about your role. I am conducting this research because there is very little research about nurse executives in home healthcare in Canada. I have been a senior nurse myself and I am aware that there are challenges that come with the job and there is not necessarily an outlet to discuss these things. You are free to decline to answer any questions, or to stop this interview at any time.

1. Tell me about how you came to be in a nurse executive position in home healthcare.
2. Tell me about any obstacles or encouragement you received when moving into the nurse executive position.
3. What does your job entail?
    a. When you took this position, was it as you expected? Did anything surprise you (positively or negatively), and if so, what? What prepared you (or not) for this position? What is a typical day like for you?
4. What is your vision for your position?
    a. Are you able to enact this vision? Why, or why not?
5. Tell me about the values that you see as important to being a nurse executive.
6. Tell me about your institution's organizational culture, especially around nursing.
7. What information do you rely on to do your job?
8. What policies, expectations, codes, do you have to follow? Tell me about them.
9. When you are asked to accomplish certain projects or activities, are you able to do so? Tell me about that.
10. Tell me about whether you are influential in your position.
11. Tell me about how autonomous you are in your role as a nurse executive.
12. What would be your ideal scenario in regard to assuming your role as nurse executive?

13. What does it take to be an effective nurse executive?
14. How do you make things work if you find yourself in a position with little leeway and you feel that you have to compromise? Can you provide examples?
15. Do you feel that you are included in all key discussions and decisions that need to be made?
16. Do you find that people understand your position and your role/responsibilities?
    a. Other executives in your organization? Managers, staff members? The larger public?
17. You are likely seen as being in a privileged, influential position. In which respects is this accurate? In which respects is it inaccurate?
18. Do you feel there are topics related to your role that are too sensitive to discuss about being a nurse executive? Tell me about them.
19. Are there any things that you feel you are not able to discuss or are not a priority?
20. What kind of supports are there, or should there be, to support you since you do not have the same kinds of protections as staff nurses for example?
21. What does it take to thrive in a nurse executive position?
22. Is there anything else that you would like to discuss or share?

Appendix L: Interview Summary Form

Participant #:
Interview completed by:
Place of Interview:
Date of Interview:
Recording: Yes / No
Other notes: Yes/No
Date Form Completed:

1. Physical description of participant
2. Physical description of the interview setting
3. Mood/tone of interview
4. What were the main issues/strengths during this interview?
5. What were the themes that struck me during this interview?
6. Summarize the information I got (or did not get) from the interview.
7. What else struck me as salient, interesting, illuminating or important about this contact?
8. What are new issues or questions that could be pursued in other interviews?
9. What are elements of the interview that could be improved?

Appendix M: Ethics Approval

23/03/2022

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

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Conditions spéciales ou commentaires / Special conditions or comments

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