

A critical organizational analysis of frontline nurses' experience of rapid and continuous change  
in an acute health care organization

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## Abstract

The aim of this study was to explore the nature of frontline nurses' experiences of living with rapid and continuous organizational change in a tertiary health care institution. The phenomenon under study was organizational change. A component of this research was also to explore the possibility of change fatigue in nurses' discourse.

Change is inevitable, and increasingly rapid and continuous in health care as organizations strive to adapt, improve and innovate in response to external pressures. These pressures challenge hospitals to strive for patient safety, quality assurance and provision of exceptional family centred care. Attending to these pressures require time, energy and money. Rapid and continuous change creates a push/pull relationship between innovation and budget. New technologies require extra resources however, simultaneous restructuring and optimization efforts see hospitals decreasing available resources. This creates a challenging workplace for nurses who must engage in organizational change activities with limited resources.

Organizational change challenges health care providers in a variety of ways because it restructures how and when patient care delivery is provided, changing ways in which nurses must carry out their work. Little research has been done regarding the impact of rapid and continuous organizational change for frontline health care providers, most notably, nurses. In this study a critical hermeneutic design was applied. Guided by the theoretical framework of critical management studies, the researcher explored concepts of organizational change, experience of change, change fatigue, and power and voice. The setting was an urban pediatric teaching hospital located in eastern Ontario. The researcher sought breadth, depth, complexity and richness of data in understanding the experience of organizational change, which supported a decision to seek a sample size of ten to fifteen participants. Thick description commenced at fourteen participants. Face to face interviews were conducted using open-ended questions to understand nurses' experiences of change. Brown and Gilligan's Voice-centred relational

method of data analysis was used – a multi-levelled analysis exploring the concept of voice in relation to self, other, culture, society and history.

Rapid and continuous organizational change in the workplace profoundly impacted nurses' work, their relationships to the self, other, culture, society and history. Nurses recognized that many change initiatives reflected an ideological shift in health care that supported a culture of service, whilst sacrificing a culture of care. A culture of service prioritized cost-savings and efficiency, which saw nurses lose the time and resources required to provide quality, safe care. Nurses felt morally responsible to uphold a culture of care, which proved challenging, and at times unobtainable. The inability to provide quality, safe care resulted in a multitude of negative emotional repercussions, which fostered moral distress. Nurses exhibited elements of change fatigue, further contributing to feelings of voicelessness and powerlessness within their workplace.

Organizational change must be re-conceptualized in ways that ensure change initiatives uphold institutional integrity and better support the provision of morally authentic nursing practice. Health care organizations should place nurses at the forefront of planning, implementation and evaluation of change initiatives in order to alleviate the many negative experiences of organizational change noted in this study.

*Keywords: Organizational change, change fatigue, power, voice, nursing work, critical hermeneutics, critical management studies*

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## **Chapter 1: Introduction**

### **Pre-understandings of Organizational Change**

I am a pediatric nurse privileged in having provided frontline care to children and their families in eleven exciting, challenging and rewarding years. Approximately seven years ago I began to see my workplace transform. Continuous and increasingly rapid rates of organizational change initiatives began to saturate the hospital. I was excited and eager to be part of these changes, as they appeared to better support nurses in the provision of nursing care. I approached changes with enthusiasm and positivity. I realized change is inevitable for an urban pediatric institution that continuously strives to receive full accreditation and serves as a pediatric trauma centre, academic teaching institution and partners with an internationally acknowledged research institute. A hospital with these affiliations has to adapt, improve and innovate in response to external pressures.

These pressures challenge hospitals to strive for patient safety, continuous quality improvement and provision of exceptional family centred care. Attending to these pressures requires time, energy and money. In order to thrive within such complex systems, pediatric hospitals require an extensive number of resources while adhering to challenging fiscal constraints. Rapid and continuous change creates a push/pull relationship between innovation and a zero-based budget. New technologies require extra resources however simultaneous restructuring and optimization efforts see hospitals shrinking other valuable resources. This creates a challenging workplace for individuals who must engage in change initiative activities with limited resources.

As a staff nurse at an institution implementing many change initiatives I began to feel overwhelmed, my positivity and enthusiasm quickly fading. I felt unable to keep up with patient care demands because of the added time required to adapt to new changes, including but not

limited to: new electronic documentation systems, new intravenous (IV) delivery pumps, narcotic infusion pumps, new medication records, unit-based medication dispensing systems, application of Lean health care improvement initiatives, adoption of a nursing professional practice model and numerous changes in leadership. All of these started to transform how I carried out my work and viewed myself as a nurse. Although I knew the intention of implementing changes was to better support me in my work, paradoxically I was taken away from the work I valued most as a nurse; being at the bedside with my patients and their families. Adjusting to new technologies, workflow processes and to the increasing expectations of nurses to take on corporate work and responsibilities caused patient-care interruptions and increasing amounts of time away from patient care. Amidst my struggles to adjust to current changes, more changes rolled out that too required periods of transition that were not reflected in the calculation of nurses' workloads.

I began to resent being forced to use new forms of technology. I resented having to change from a paper-based document system to an electronic one because retrieving and entering patient-care information now took me double and triple time to perform these tasks. In fact, documenting my assessments took longer than performing them. I begrudged being made to reorganize the traditional way of performing nursing care simply so I could document in a pre-determined manner. I became angry about working with new intravenous pump technology because I spent more time troubleshooting technical problems than using the pumps to administer patients' medications. I resented making the organizational changes based on indirect patient-care priorities because of the guilt I felt not spending more time delivering direct patient care to my patients and their families. I struggled to understand the rationale for changes, whilst feeling disengaged and disempowered by the decision-making process. I believed there were more advantageous ways of implementing changes that better supported nurses in their work and improved patient outcomes. In my mind, the wealth of institutional nursing knowledge was not used for decision-making that directly impacted nursing practice. Nurses were minimally, if ever consulted. I felt powerless in the change process; however, I was

afraid to speak out. As the organization framed changes in ways that would ultimately result in better patient care and outcomes, if I spoke out, was I speaking against enhancing quality patient care delivery? Or, was I honestly voicing concerns about the serious negative impact on the quality of the nurses' work life that needed to be addressed? I questioned if the organization perceived the latter concern as less important than patient care, but I believed both should both be of equal consideration.

I was not alone in my feelings of frustration and disillusionment. I realized my nursing colleagues were experiencing these changes in similar, disheartening ways. The increased workload associated with rapid and continuous changes took its toll. Staff morale was the lowest I had ever experienced. Teamwork suffered. Nurses struggled to complete nursing tasks for their assigned patients, so much so that we found ourselves too stretched to offer a helping hand to colleagues without feeling overwhelmed and stressed. For many of us, teamwork and helping others defines us as nurses. I eventually felt inadequate because I could not manage my workload nor help my colleagues and the children for whom we all cared and felt responsible for. Yet we continued to stretch ourselves thin to support each. We achieved this by self-sacrificing behaviours such as skipping meal and coffee breaks, which quickly became normal behaviour.

Malfunctions and failures of new equipment, and new technologies and workflow processes challenged us in ways that left some of us feeling burnt out, exhausted and apathetic. Apathy arose from seeing no end in sight, as every change had another one close on its tail. Indeed, daily staff communiqués consisted of large volumes of updates on recently implemented changes or forecasts of more to come. A job that I once loved passionately became one that filled me with daily angst. I felt the need to disengage from my workplace.

We were offered different explanations from leadership as to why we were not seeing improvements in our work lives. We were told that we needed to give change initiatives a fair amount of time in order to produce positive outcomes and that periods of disruption were a

natural part of change. These explanations did little to reassure us about the quality of our nursing care or work lives. Moreover, managers began to interject the word “resistance” when referring to our responses to the challenges we faced as a result of change. Some nurses were deemed resistant to change therefore impeding its smooth operation. These assumptions silenced nurses’ voices and left us feeling powerless to meaningfully engage in the change process.

Intrigued and unsettled by the blame put on nurses, I began reading about nurse resistance and organizational change. I concluded that what I experienced in my workplace was something very different from resistance. We were not exercising resistance; we were drowning in our day-to-day workloads. We were coping with an immense internal struggle to strive for excellence in a rapidly and continuously changing environment; struggling to hold on to what defines us as nurses.

In order to understand what was happening in my workplace I took a step back, immersed myself in academic literature and connected it to my own experiences as a nurse. This evolving process lead me here, six years later, reporting the findings of my doctoral research study that explored nurses’ experiences of rapid and continuous change in health care. Changes in health care organizations [HCOs] are inevitable in today’s social, economic, legal and technological contexts. However, if change initiatives impede rather than support nursing care provision, this must be examined. Researching nurses’ experiences of rapid and continuous change constitutes the focal point of this exploration.

### **My Epistemological Stance**

Graduate studies challenge students to reflect upon how they’ve come to know social reality and what sets of beliefs and assumptions have shaped that reality (Newman, 1991). I believe we work within a multitude of complex social interactions to create our reality and the human experience, a belief that reflects a constructivist paradigm (Guba & Lincoln, 1989). Individuals’ preconceptions are vital to the process of understanding our lived experiences.

Many of my preconceptions come from being raised in a community that experienced high levels of poverty, where I grew up socioeconomically disadvantaged. It was in those years that I became acutely aware of the complex social interactions that shape societal norms and expectations across varied socioeconomic groups, which often results in large divisions based on social class. As I moved on to university to obtain my nursing degree I became familiar with the concept of voice when I began to volunteer with vulnerable, socioeconomically disadvantaged populations, who were often voiceless. I was taught in my undergraduate curriculum that nurses were the strongest patient advocates speaking out for those who often did not have their own. When I graduated university and began my nursing practice, I saw that for many reasons nurses often did not have their own voices when it came to professional concerns, yet were excellent patient advocates. This angered me, as I had worked very hard to enter a profession I believed had a voice in health care discourse, both for patients and nurses.

Understanding is possible only because we are all connected by a human consciousness (Gadamer, 1989), where “knowledge is a living, evolving process of coming to know rooted in everyday experience” (Reason & Bradbury, 2001, p. 2). Experience is the fundamental source of knowledge (Husserl, 1970). Although these experiences are unique for every individual, they are co-constructed through complex relations of power (Hayes & Oppenheim, 1997). Therefore, my doctoral work is grounded in an epistemology of constructivism as intersected with both voice and power.

I understand constructivism as an active co-creation of knowledge and the world in which we exist between self and others. Constructivism honours the relationality of social structures and practices, people and the phenomena that shape organizations, and the lives of those within them (Bradbury & Bergmann Lichtenstein, 2000). Organizations are thus a construction of these relations. Bradbury and Bergmann Lichtenstein suggest there is a *space between* that exists in organizations, which consists of phenomena and experiences constructed by relationality that we don't yet understand. The *space between* occurs when

social structures and practices, people and phenomenon engage to create complex organizations. In order to understand this *space between* and thus stimulate unique knowledge development we are required to utilize novel lenses and methodologies that reflect frameworks of relationality in the examination of complex organizations (Bradbury & Bergmann Lichtenstein, 2000).

I view organizations, which are political constructs, through a lens of power relations (Bradbury & Bergmann Lichtenstein, 2000). Power is an omnipresent, creative force, both productive and oppressive, that resides within individuals and the structures in which they dwell (Foucault, 1980). An individual's perception of their own power is directly related to their alignment to prevailing discourses, which in HCOs is often reflective of managerial perspectives. Frontline nurses perspectives do not always align with this prevailing discourse. This results in a "self-positioning of employees within managerial-inspired discourses" (Alvesson & Willmott, 1996, p. 629). When nurses live within managerial motivated discourses it results in underrepresentation of nursing knowledge, disregard for the physical and emotional toll of their work and disallows them to participate in decision-making processes.

Yet hearing nurses' stories of demonstrated resiliency and perseverance, I am hopeful for the future of nursing and its associated knowledge within the Canadian health care system. This hope comes from a place of critique, for to cultivate hope we must believe things can be different. When we acknowledge and challenge taken-for-granted assumptions of day-to-day organizational life we see a multitude of perspectives that may have been historically overlooked or repressed, often for political reasons. To better understand health care in all its complexity, space must be made for nurses to voice their knowledge and truth claims.

### **Research Objectives**

This study explored the nature of pediatric frontline nurses' experiences living with rapid and continuous organizational change in a tertiary-care HCO. The research questions that guided this exploration were:

1. What types of rapid and continuous change are frontline nurses experiencing?
2. How are nurses experiencing rapid and continuous organizational change?
3. How does rapid and continuous organizational change impact the way nurses conduct their work?
4. Does nurses' discourse about rapid, ongoing organizational change reveal evidence of feelings and behaviours that may reflect elements of change fatigue as currently described in the literature?
5. What positively and negatively influences nurses' experiences of rapid and continuous organizational change?
6. How do perceived levels of power influence nurses' experiences with rapid and continuous organizational change?

## Chapter 2: Literature Review

A preliminarily broad search of the literature was completed using the following terms; *nurse, nursing work, organizational change, health care, healthcare*. Databases utilized included PubMed, CINAHL, Abi/Inform, ProQuest and Psychinfo. This was done to gain an initial overview of available literature and to provide direction for the refined literature review used to frame this study. Six keywords emerged from the preliminary search. A comprehensive literature search was conducted using those six keywords: *organizational change, nurse, nursing, health care, change resistance, change fatigue*.

Resulting literature was heavily derived from management journals and texts, and at times discussed disciplines outside of nursing but still within the public sector. These texts were most notably associated with the sixth keyword *change fatigue*. At the time of the search, no nursing literature explicitly describing change fatigue was found, but because I believed the concept had potential to exist in nursing, I included it in the key words search for the subsequent literature search. It was important to include databases that provided organizational scholarship, as much of health care's understanding of organizational change has come from this parent literature. No time limits were applied to the search, which facilitated a better understanding of the evolution of organizational change over time.

This literature review is organized into four sections. The first section is a broad conceptualization of change. The second is a summary of facilitators and barriers to organizational change. The third is a discussion of emergent, central concepts associated with the outcomes of organizational change. The fourth section, a discussion of current knowledge gaps, highlights the need for alternative methods of inquiry. A significant finding in the literature search is the dearth of Canadian studies, meaning that Canadian context is largely missing from current scholarship.

### **Conceptualizing Organizational Change**

Change in health care is rapid and continuous, largely due to fiscal influence and restraint but also as a result of swift advances in health care technology, managerial structures, and scopes of practice for both regulated and non-regulated health care workers. The change initiatives being introduced result from the need to improve internal processes, maximize efficiency, and adapt to external influences including health care policies, legal frameworks and scientific advances (Bernerth, Walker, & Harris, 2011, Daly, 2014). For the purpose of this study, rapid and continuous change is understood as multiple initiatives that are intentionally implemented by the organization in a fast and ongoing nature to alter one or more aspects of frontline health care delivery.

Organizational change in HCOs includes expansive initiatives that impact multiple disciplines, departments and services across the organization, such as the implementation of electronic health records and medication administration cabinets. In addition, organizational change in HCOs includes smaller changes that may involve only nursing, or only specific units. Examples are the standardization of nursing practices or the implementation of unit specific policies and guidelines.

Organizational change modifies structures, roles, and procedures of organizations and the people within them (Barnett & Carroll, 1995). It is adaptive and transformative for those who are exposed to change as they explore, learn and innovate new ways of thinking and working in response to new initiatives (Campbell, 2000; Orlikowski, 1996). The experience of change includes “ongoing and situated accommodations, adaptations and alterations” (Orlikowski, 1996, pg. 64). Alterations are described as the redistribution of work and responsibility, ways of knowing and doing and the changing of collaborative and team working strategies (Orlikowski, 1996). Small tasks, previously completed successfully and swiftly, now take more time as cognitive and practical accommodations are processed and carried out (Orlikowski, 1996).

Organizational change requires learning, disrupts routines and alters relationships in organizations (Hannan & Freeman, 1984).

Organizational change is “inseparable from the ongoing and situated actions of organizational members” (Orlikowski, 1996, p. 67). Organizations consist of many members often with differing ideas about change, so the change process becomes complex when multiple members are engaged (Allan et al., 2014; Buchanan & Dawson, 2007). Multi-authored processes require multi-authored dialogues to bring about differing experiences and ideas that help understand complex change process (Allan et al., 2014; Buchanan & Dawson, 2007).

Organizational change is complex and political (Buchanan & Dawson, 2007) but is also linear and sequential with predictable outcomes (Weiner, Amick, & Lee, 2008). This perpetuates simplistic ideas about the assessment, planning, implementation and evaluation of organizational change initiatives (Bazzoli et al., 2004; Weiner et al., 2008). Narrow conceptualizations can account for the limited outcome measures used to evaluate organizational change (Weiner et al., 2008) and the narrow understanding of success as compliance, and failure as resistance (Bazzoli et al., 2004; Buchanan et al., 2005).

### **Facilitators and Barriers to Organizational Change**

Three key themes emerged from the literature review that were perceived as either facilitators or barriers to organizational change. They included power, work life satisfaction and business management orientation.

#### **Power**

Perceived levels of power, particularly as it applies to involvement in and influence on organizational decision-making, has uniquely shaped individuals' experiences of organizational change (Barrett, 1983; 1989; Espedal, 2017; Hunter, 2008; Jones et al., 2008). Organizational research has highlighted that higher employee levels of perceived power in decision-making processes resulted in higher levels of change success and sustainability and greater levels of

work life satisfaction (Buchanan & Fitzgerald, 2007; Kim et al., 2006; Kim, 2009; Kotter, 1995; Tholdy Doncevic et al., 1998).

The reality of organizational life for nurses has rarely reflected high levels of decision-making power in change initiatives (Kuokkanen et al., 2007). Further, organizational members' experiences of decision-making have been largely neglected in health care literature and require further investigation (Fulop & Mark, 2013). McKee, Ferlie, and Hyde (2008) recognized that increasing complexity within HCOs makes decision-making "imperfect, messy and highly political" (p. xxvii).

The Change process can fundamentally redefine and reshape power relations within organizations (Learmonth, 2008; Pfeffer, 1981). Rapid changes in HCOs have fostered feelings of dissent fuelled by lack of existing opportunities to exercise power and influence in decision-making (Kuokkanen et al., 2007). In contrast, increased perceived abilities to engage in and influence the change process decreased nurse stress and burnout (Korunka et al., 1993; McGibbon et al., 2010). Similarly, researchers revealed that increased levels of power in decision-making decreased staff stress associated with change, heightened staff engagement in change initiatives, and increased the likelihood of successful and sustainable change (Cunningham et al., 2002; Fugate, Prussia & Kinicki 2012; Kuokkanen et al., 2007).

Fugate and colleagues (2012) studied the management of employee withdrawal during organizational change and focused on the role of threat appraisal in a department within a public service organization in the United States. They found negative relationships between threat appraisals and a positive change orientation, which included self-efficacy, positive attitudes toward change, and perceived control of changes. More specifically, change initiatives that threatened job security, relationships with co-workers and supervisors, job desirability, pay and benefits, job opportunities and general working conditions increased employee rates of absenteeism and intentions to quit. When employees felt more threatened by change, they felt they held less power (Fugate et al., 2012), whereby "changes precipitate tremendous stress for

employees and result in an array of negative outcomes for employees” (p. 892). The authors concluded that employee threat appraisal is an important explanatory factor of employee behaviour in the context of organizational change and helps explain variation in individuals’ experiences and reactions to the same change event. Fugate and colleagues (2012) suggested that threat appraisal helps explain why some employees quit because of change while others do not.

Tholdy Doncevic et al. (1998) conducted a study comparing stress, job satisfaction, perception of control, and health among community-based district nurses in Sweden and Croatia during periods of organizational change. The longitudinal study consisted of self-administered surveys that explored sources of job stress, perceptions of control, cognitive demand and job satisfaction. Tholdy Doncevic and colleagues (1998) found the most stressful factors for nurses during periods of organizational change were work overload and decisions about changes made at higher ranks. High levels of organizational change were directly associated with low degrees of influence and control (e.g., power) and low perceived levels of participation in both organizations. These researchers concluded that very different social systems and standards of living influenced the way nurses worked in their unique health care systems. They cautioned against generalizing nurses’ experiences of work-related stress and articulated that future research should explore the uniqueness of nurse job stress in relation to their areas of practice and the countries in which they practice (Tholdy Doncevic et al., 1998).

Kuokkanen and colleagues (2007) explored the relationship between organizational change and empowerment in an acute-care centre in Finland. The management structure within the organization had changed from traditional hospital organization to an internal ordered–producer model, which meant external middle management candidates were brought in to manage operations, not units. For example, newly hired management was called product managers and resource managers. The longitudinal study utilized a self-administered structured questionnaire. These researchers found that organizational change negatively impacted

empowerment for staff when it was carried out in ways that demonstrated strong organizational bureaucracy and hierarchy, authoritarian leadership, poor access to information and little opportunity for staff advancement in relation to restructuring. Kuokkanen and colleagues (2007) concluded that organizational change had a direct effect on work environments and may have contributed to increased rates of health care worker dissatisfaction, burnout and absenteeism. Hertting and colleagues (2003) explored stressors and motivators for medical secretaries following organizational change that resulted in structural changes and decreased personnel between 1997 and 2000 in a large hospital in Sweden. The researchers used a descriptive qualitative method. Hertting et al. (2003) found the participants described organizational change they experienced as “energy thieves” (p. 164), which left them with too much work. The participants also reported a lack of recognition from management for the extra work required to cope with changes. Participants struggled with balancing health, family and finances during periods of organizational change. They experienced difficulty managing the changes and were conflicted about “being submissive or taking action” (p. 161) and as a result most became passive and apathetic. Hertting et al. (2003) concluded that health care workers had extremely demanding work realities, which increased during periods of organizational change. Workers needed time to adjust to, and be recognized for, the difficulties associated with change. Hertting and colleagues (2003) also suggested that power plays a significant role in organizational change and that future research should expose injustices and feelings of inferiority experienced by health care workers.

Struggle for power fuels feelings of powerlessness in day-to-day decision-making processes (Korunka et al., 1993; McGibbon et al., 2010). If day-to-day work lives of nurses are increasingly stressful in nature (often leading to burnout) due to established struggles for power, the stress associated with low levels of control and influence during periods of organizational change may further compound pre-existing stressors in nurses’ day-to-day work lives including workload, lack of resources and staffing shortages (Tholdy Doncevic et al., 1998).

## **Work Life Satisfaction**

Organizational change in health care is necessary and beneficial for patients and health care providers (CNA, 2009). Nevertheless, rapid and continuous organizational change challenges health care providers in a variety of ways because it restructures how and when patient care delivery is provided, changing ways in which nurses must carry out their work (Campbell, 2000; Kuokkanen et al., 2007). Nurses' work lives have been impacted by organizational change dating back to restructuring efforts in the early 1990s (Hamric, Spross & Hanson, 2009; Rankin & Campbell, 2006). Yet Dossey (2008) reminds us "we do not consistently listen to the pain and suffering that nurses' experience within the profession" (p. 55). Tholdy Doncevic and colleagues (1998) reported the highest levels of self-reported stress for frontline nurses in Sweden were directly related to ongoing changes and subsequent reorganization of nursing work. The literature is replete with Canadian-based research that has continuously demonstrated that nurses' high stress levels result in low levels of job satisfaction, increased absenteeism and increased rates of attrition (Aiken et al., 2001; Aiken et al., 2002; Dunleavy et al., 2003; Duxbury et al., 2010; Spreitzer & Mishra, 2002; Tholdy Doncevic et al., 1998). These outcomes continue to impact the nursing profession (Canadian Nurses Association [CNA] & Canadian Federation of Nurses Unions [CFNU], 2003; CNA, 2009).

The experience of stress, exhaustion and burnout are not new to the discipline of nursing and continue to receive attention from nursing associations across Canada. Commitment and support for the promotion and safeguarding of nurses' work lives and well-being have been offered through various professional nursing organization initiatives. Examples include the Best Practice Guideline entitled, Preventing and Mitigating Nurse Fatigue in Health Care (Registered Nurses Association of Ontario [RNAO], 2011) and the paper entitled, Social Determinants of Health and Nursing: A Summary of the Issues (CNA, 2005). These initiatives are structured to advocate for and create work environments that foster nurse well-being and support the integrity of nurses' work.

Tholdy Doncevic et al. (1998) and Hertting et al. (2003) noted the importance of exploring organizational change in unique practice areas of health care, warning against the generalization of findings. Pediatric nurses are a unique group of health care providers that are not yet represented in organizational change literature. Routinely, acute-care pediatric nurses are exposed to high stress levels in their day-to-day work lives. As Schwerman and Stellmacher (2012) noted, “pediatric hospitals are fast-paced, high stress work settings” (p. 385). Pediatric nurses experience high rates of compassion fatigue and burnout (Akman et al., 2016; Alexandros et al., 2011; Jacobs et al., 2012; Maytum, Bielski Heiman & Garwick, 2004; Taubman-Ben-Ari & Weintraub, 2008). This is largely because, “When the patients are children, the circumstances are much more stressful” (Taubman-Ben-Ari & Weintraub, 2008, p.637). The complexities of contending with the distress of pediatric patients, their family members, and nurse’s personal responses to caring for acutely-ill children are contributing factors (Taubman-Ben-Ari & Weintraub, 2008). What is unknown is how the increased demands brought on by rapid and continuous organizational change in pediatric institutions further impact pediatric nurses work lives and stress levels. Taubman-Ben-Ari & Weintraub (2008) argued, “further investigation is needed to identify factors that might moderate the work-related stress of pediatric nurses” (p.640). Tholdy Doncevic and colleagues (1998) suggested that future research should explore the uniqueness of nurse job stress in relation to their areas of practice and the countries in which they practice (Tholdy Doncevic et al., 1998). Despite this recommendation, there remains a lack of Canadian, pediatric nursing research on the subject of organizational change.

### **Business Management Orientation**

HCOs are more frequently being described as businesses where business management models of organizational hierarchies are increasingly commonplace (Campbell, 2000). However, this shift in health care ideology and delivery has been associated with decreased work life satisfaction and feelings of powerlessness amongst nurses (Iles & Sutherland, 2001; Rankin &

Campbell, 2006). Deffenbaugh (1994) suggested that, "Health care should be viewed as a continuum of businesses and services aimed at 'satisfying' customers" (p. 37). This ideological shift from models of care to business management models is evident in current health care discourse. Discourse reflects this ideological shift by continuously employing the use of words that imply some level of business interaction, such as streamlining, efficiency, care production, care management, and client or consumer (Campbell, 2000; Rankin & Campbell, 2006; Ratnapalan, 2009). Staffing structures also reflect business management models. For example, HCOs now use such titles as chief executive officers, directors, staffing officers, change management staff and information technology staff. Iles and Sutherland (2001) argued that change management models in health care are "overly influenced by the normative ideas of management gurus" (p.13), suggesting change management literature is often irrelevant for frontline staff working in clinical areas of health care.

This ideological shift away from a health care orientation of management is further highlighted by the increasing utilization of factory and industry business management models for restructuring health care efforts to address what has been cited as "inefficiencies in health care delivery" (Kim et al., 2006, p.191). In attempts to streamline care Six Sigma and Toyota's Lean models have been implemented in many health care restructuring initiatives (Fulop & Mark, 2013; Kim et al., 2006). Conversely, two systematic reviews found very little evidence of the effectiveness of the Six Sigma (DelliFraine et al., 2010) and Lean (DelliFraine et al., 2010; Moraros et al., 2016) in health care, stating that "While some may strongly believe that Lean interventions lead to quality improvements in health care, the evidence to date simply does not support this claim" (Moraros et al., 2016, p. 150). DelliFraine et al. (2010) suggested a significant finding in their systematic review was the scarcity of literature reporting on the failure of Six Sigma and Lean, noting not one of the 34 articles articulating outcomes discussed any measure of failure. DelliFraine and colleagues (2010) asserted that this reflects a publication bias, noting the published literature to date may be misleading health care management. This

assertion further supports suggestions that literature associated with some highly popular organizational change practices disproportionality represents few and narrow perspectives on the subject of organizational change.

Advice and guidance from disciplines outside of the health care field have guided much decision-making regarding organizational change (Rankin & Campbell, 2006) with minimal consultation with frontline staff who are responsible for enacting and sustaining these change initiatives (Litcheffeld & Jónsdóttir, 2008). According to these same authors, current health care systems are increasingly being driven by cost effectiveness where dollars are speaking louder than nurses' voices. Axelsson (2000) and Thurlow (2007) suggested that changes are haphazardly made to fix faltering systems, leaving strategic planning and timing at the wayside. In addition, reliance on business management frameworks for change initiatives in health care minimizes the recognition of multiple yet distinct organizational cultures within HCOs (Beil-Hildebrand, 2005). This becomes problematic as the variety of organizational cultures within HCOs make change implementation unique and challenging (Beil-Hildebrand, 2005). The reliance on business management frameworks may thus contribute to the high rates of change failure in HCOs discussed by Dickson and colleagues (2012). Fulop and Mark (2013) suggested that business management models reflect linear cause and effect problem-solving scenarios and argued that when linear thinking guides change models in complex organizations, change initiatives fail. Furthermore, they stated that the risk for change failure further increases when implemented at high speeds.

The failure of change initiatives in HCOs also suggests that persons, contexts and cultures have not been taken into account or have not been properly addressed by business management frameworks and discourses. For example, research to date has largely focused on the efforts of organizational change to address health care costs and hospital finances with little research addressing other impacts associated with change, such as staff well-being and work-life satisfaction (Bazzoli et al., 2004; Rankin & Campbell, 2006). This omission has been noted

in the industries of finance, manufacturing, education, and high technology where Herold et al. (2007) suggested that the exclusion of person and/or context and culture in change management results in frequent disappointing results of change initiatives. These same omissions in health care discourse perpetuate the underrepresentation of certain organizational members (nurses) and cultures (nursing) within organizational discourses (Alvesson & Deetz, 2000), thus challenging nurses' ability to influence not only their role within HCOs, but also the future direction of health care in general.

Current literature describes how and when frontline nurses are involved in change initiatives, but nurses' experiences within change initiatives remain minimally explored (Rankin & Campbell, 2006; Wall, 2010). It has been suggested that the research and practice of change management would "do well to focus not only on aspects of the particular change, but also on the context in which change occurs and the individuals undergoing change" (Herold et al., 2007, p. 949). Doing so may offer a broader understanding of how organizational members experience change, and what the array of outcomes may be.

### **Outcomes of Organizational Change**

Four key outcomes emerged from the literature review of organizational change: change failure, change resistance, change fatigue and altered perceptions of professional identity. These concepts reflect the predominant impacts of organizational change on employees.

#### **Change Failure**

Increased rates of change have been associated with increased rates of change failure (Campbell, 2000). The reasons for change failure, however, have been primarily explored from managerial perspectives and consequently resistance has been described as the main reason for change failure (Axelsson, 2000). Dent and Goldberg (1999) suggested that the concept of resistance often misrepresents and oversimplifies what occurs within the change process, and advocated for the exploration of change failure beyond associations with change resistance.

Historically, when organizational change failed or was unsustainable it was thought that workers were not maximizing productivity or working optimally (Perrow, 1986). Change failure was investigated in ways that laid blame on employees (Perrow, 1986), a narrow conceptual understanding of change that continues to construct contemporary change discourses. There has been little, if any, shift in this mentality, noting that popular writings on the subject of organizational change continue to burden employees for change failure (Battilana & Casciaro, 2013; Herold et al., 2007; Ford & Ford, 2010; Kotter & Schlesinger, 2008; Reisner, 2002) Focus on individual behaviours within organizations is evident in nursing scholarship where failed organizational change initiatives are often blamed on nursing staff and their resistance to change (MacGuire, 2006; Rankin & Campbell, 2006).

It has been suggested that change failure in Canada's health care system is high because it is "a country of perpetual pilot projects" (Bégin, Eggertson & Macdonald, 2009, p. 1185). Pilot projects often demand rapid, yet short, and unsustainable periods of change. The compilation of multiple pilot projects has the potential to create work environments that put frontline health care staff at risk of experiencing apathy, disengagement, exhaustion and burnout (Beil-Hildebrand, 2005). There is a paucity of research that has examined the impact of change for those employed in rapidly changing workplaces (Bazzoli et al., 2004; Rankin & Campbell, 2006).

### **Change Resistance**

The concept most often associated with nurses' responses to the restructuring of their work as a result of organizational change has historically been resistance. Resistance to change is cited as nurses' shortcomings, which are characterized as obstructive and even destructive to change initiatives (Elrod & Tippett, 2002). Resistance to change is constructed as a problem that requires fixing with the responsibility to do so seemingly resting in the hands of managers (Harvey, 1990). The concept of change resistance has been extensively explored in organizational scholarship (Beil-Hildebrand, 2005; Bernerth et al., 2011; Dent & Goldberg, 1999; Ford, Ford & D'Amelio, 2008; Merron, 1993; Nord & Jermier, 1994; Stensaker & Meyer, 2012;

Thomas, Sargent & Hardy, 2011; Torppa & Smith, 2011; Umiker, 1997) and to a lesser extent in nursing literature when framed within an organizational change context (Bonalumi & Fisher, 1999; Cope et al., 2016; Kan & Parry, 2004; Kerridge, 2012; Swansburg & Swansburg, 2002).

The concept of change resistance has been largely examined through a systematic management science lens where change is seen as predictable and controllable (Capra, 2003). Strategies to overcome resistance with the aim to increase productivity and decrease rates of change failure have frequently been studied in the change resistance literature (Herold et al., 2007; Umiker, 1997). Nursing researchers have primarily focused on managements' attendance to nurse resistance, and have not framed their research from a frontline staff nurses' perspective of organizational change (MacGuire, 2006). Strong managerial representation in the change resistance literature has fostered the invisibility of frontline nursing's voice (Elrod & Tippett, 2002). This mirrors the dominant resistance discourses in organizational change research.

Behaviours associated with change resistance have been described as active responses to change, both verbal and nonverbal. Verbal behaviours identified include cynical remarks, critical questioning and denying the need for change (Abraham, 2000; Bernerth et al., 2011). Nonverbal behaviours include eye rolling; knowing looks and smirks (Brown & Cregan, 2008). Resistant behaviours have been described as those that are directly aimed at those in charge of change initiatives and often displayed through informal discussions (Brown & Cregan, 2008). Resistance to change becomes blatant when individuals make their position publicly known. When management becomes explicitly aware of such resistance in the workplace, they more often than not attempt to counteract and halt resistant behaviours (McMillan & Perron, 2013).

### **Change Fatigue**

We live in a society facing uncontrollable change, uncertainty and crisis resulting in an ideology that embraces change as "positive, necessary and all encompassing" (Morgan & Spicer, 2009, p. 251). Such affinity for change creates a culture whereby changes becomes un-

noticed, omnipresent phenomena (Tsoukas & Chai, 2002). It is suggested that day-to-day working lives have become so flexible and fluid in response to continuous change that they have created increased anxieties and widespread senses of insecurities amongst staff (Tsoukas & Chai, 2002). Staff members experiencing widespread insecurities are at higher risk for increased levels of stress, exhaustion and burnout (Tsoukas & Chai, 2002), key elements of the phenomenon identified as change fatigue (McMillan & Perron, 2013).

Current scholarship has identified that during periods of organizational change employees experience increased levels of stress, exhaustion and burnout accompanied by feelings of ambivalence and powerlessness (Allan et al., 2014; Coid & Davies Huw, 2007; Korunka et al., 1993; McGibbon, Peter & Gallop, 2010, Tholdy Doncevic, Romelsjö, & Theorell, 1998). These feelings do not coincide with traditional definitions of resistance. Rather, they have been collectively described as the phenomena of change fatigue. The concept of change fatigue has been used interchangeably with the concept of change resistance (Dent & Goldberg, 1999; Kiefer, 2005); yet striking differences exist between the two and are worthy of further exploration (McMillan & Perron, 2013). Both change resistance and change fatigue contribute to change failure (Buchanan & Fitzgerald, 2007) yet they are very different concepts.

Change fatigue has been described as overwhelming feelings of stress, exhaustion and burnout fuelled by feelings of ambivalence and powerlessness associated with rapid and continuous change in the workplace (Allan et al., 2014; Buchanan et al., 2005; Bernerth et al., 2011; Brown & Cregan, 2008; MacIntosh et al., 2007; Torppa & Smith, 2011). Experiencing change fatigue may cause workers to become withdrawn and has greatly influenced their decision to leave the workplace and even their profession (Abraham, 2000; Bernerth et al., 2011). Change fatigue includes passive behaviours such as disengagement, apathy, and ambivalence (McMillan & Perron, 2013). Staff members who experience change fatigue have been further described as feeling disempowered, burnt out, and disillusioned (Brown & Cregan, 2008). Change fatigue is a complex process embedded in social interactions and emotions

where knowledge and meaning are generated from the interactions between one's ideas and experiences with change (Capra, 2003). However, when exploring this concept, it appears employees' concerns have not been openly expressed and dissent has not been apparent, although it has been explicitly felt (Buchanan et al., 2005). Silent dissent is a direct response of staff's exhaustion when attempts at being engaged with the change process have been futile (Buchanan et al., 2005; Wall, 2010). Change fatigue has been associated with increased rates of employee sick time (Hansson et al., 2008). In contrast, resistance to change has not been associated with increased absenteeism (Johnson & O'Leary-Kelly, 2003). At a time when nursing shortages are increasing and staffing concerns continue to be at the forefront of many health care discussions (CNA [Canadian Nurses Association], 2009; CNA & CFNU [Canadian Federation of Nurses Unions], 2015; RNAO [Registered Nurses Association of Ontario], 2017), change fatigue has the potential to negatively impact the health care system by increasing rates of sick time and absenteeism in nursing.

Compounding concerns associated with change fatigue are discussions of nurse well-being. To function optimally the health care system requires healthy nurses. The best way to keep nurses healthy in their workplaces is to minimize undue stress, exhaustion and burnout (RNAO, 2011). It has been reported that frontline staff nurses increasingly experiencing high levels of stress, burnout and exhaustion due to workplace demands (Baumann et al., 2001; Canadian Nursing Advisory Committee, 2002; Dossey, 2008; Dunleavy, Shamian, & Thomson, 2003; Duxbury, Higgins & Lyons, 2010; McVicar, 2003; Pearson et al., 2004; RNAO, 2011). Current studies on workplace stress, burnout and exhaustion in nursing have focused on impacts of the nursing shortage, fiscal restraint and restructuring efforts. In response to the current climate of ongoing change in health care it is important to examine the role organizational change may play in nurse stress, burnout and exhaustion. Bernerth and colleagues (2011) suggested that change process are at times destructive to employees and their professions and that high burnout rates, exhaustion and staff withdrawal are direct results

of periods of rapid and/or continuous organizational change. The experience of change fatigue greatly influences employee's decision to leave the workplace and even their profession, two issues that already affect the Canadian nursing workforce in disproportionate ways (CNA, 2009; CNA & CFNU, 2015; RAO, 2017).

Passive behaviours associated with change fatigue, including apathy and disengagement, have the potential to be misinterpreted by management as agreement, compliance and even readiness for more change. Such misunderstanding has the potential to create a cyclic chain of events wherein more and more changes are implemented by management inadvertently amplifying nurses' potential to experience change fatigue. In addition, when organizational change initiatives fail, more changes are implemented to try to rectify the failed initiative. High rates of organizational change increase nurses' risk for experiencing stress, burnout and/or potential change fatigue.

In contrast, change resistance has been discussed as positive and even necessary for organizations in small doses because resistance stimulates increased levels of critical reflection regarding organizational change initiatives (Ford et al., 2008; MacGuire, 2006; Thomas et al., 2011; Umiker, 1997). No literature was found that described any benefits associated with the experience of change fatigue. What is unclear and difficult to delineate is the discussion of perceived and felt optimism surrounding change initiatives. Both change fatigue and resistance have elicited low levels of optimism from frontline staff, but for different reasons. Decreased optimism associated with change resistance is a result of a history of repeated organizational failures (Abraham, 2000; Bernerth et al., 2011). With change fatigue, decreased levels of optimism have been associated with burnout and stress resulting from the rapid and continuous change implementation (Bernerth et al., 2011). Perhaps change fatigue may be easier to address and alleviate since the associated behaviours do not appear to be engrained, unlike those behaviours associated with resistance to change that have been historically repetitive in nature.

Further exploration of change fatigue in nursing will provide ways to better understand organizational change as experienced by frontline staff beyond the concept of change resistance. Organizational literature has linked change fatigue to industries outside of health care, however the concept has yet to be researched within the discipline of nursing; currently only theoretical propositions exist (McMillan & Perron, 2013). One of the driving motivations to explore the possibility of change fatigue in nursing practice is that historically resistance has been normalized as the dominant explanation of any non-compliant behaviors nurses demonstrate in relation to change. Alternative concepts, and thus nurses' experiences of such, are at risk of continuing to go unacknowledged, as suggested by Meleis (2007):

A concept may have been accepted in the daily experiences of nurses, yet because it is embedded in the nursing experience, its existence and priorities are normalized, thereby camouflaging and limiting the concept's growth and meanings (p. 372).

### **Altered Perceptions of Professional Identity**

Allan and colleagues (2014) studied professionals' and managers' experiences of governance and funding incentives during periods of organizational change in three primary health care settings in England between 2006 and 2008. Team structures and professional roles had undergone significant changes to governance and funding structures during the United Kingdom's attempts to shift health care services from primary to community settings. The longitudinal study consisted of group interviews conducted with service users, and individual interviews conducted with managers and frontline health professionals. Allan and colleagues (2014) found that the integration of effective new interprofessional models was a slow process, especially if the "painful feelings involved in change [were] not acknowledged" (p.93) and structures did not support staff during periods of uncertainty associated with organizational change. They concluded that the multiple perspectives found depended on individual occupational positioning in new team configurations. Multiple perspectives illuminated the need to incorporate emotional, technocratic and system factors when implementing change. In

addition, Allan and colleagues (2014) conclude that voice must be given to all health care providers when implementing system change. They argued that conceptual thinking about organizational change should take more account of the emotional domains of change; the heterogeneity of professional identities and the impact change has on work lives.

Purcell and Milner (2005) conducted a study that explored clinical nurse managers' experiences of organizational change at an acute-care hospital in Ireland during national health reforms. Dramatic health reforms in Ireland's National Health Service (NHS) had greatly impacted the nurse managers' development and little was known about their experiences during this period. These researchers found that reforms to Ireland's NHS resulted in bureaucratic HCOs that fostered complex and difficult work environments for nurse managers, where they felt pressured by both national and local health care agendas. They concluded that shortcomings existed in the ongoing development and support of nurse managers during health reform and that role clarification for nurse managers was required during periods of health reforms. Purcell and Milner (2005) identified large gaps between what should be done and what was actually done in regard to the practices of these nurse managers in the NHS in Ireland.

Similarly, Paliadelis and Cruickshank (2008) who also explored the working world of nursing unit managers during organizational change in HCOs found that professional roles become unclear due to the rapid and continuous nature of change. They asserted that when unrealistic expectations inherent in many change initiatives are imposed on health care employees, the resultant roles become unclear and a source of stress and self-uncertainty.

Hewison (2012) conducted a qualitative study exploring nurse managers' experiences of organizational change at a large, acute care NHS hospital in England. Hospitals in England were undergoing large structural changes where departments were being realigned, resulting in the disbanding and reorganizing of wards, departments and associated staff. Hewison (2012) found managers attempted to cope with a rapid change of pace that was a daily reality. Managers who identified firstly as nurses (in contrast to managers who did not) felt that

communications with frontline staff nurses were more effective and that change implementation was a smoother process. This was deemed significant in that professional identities particularly influenced management practice. Although change models were described by managers, they were rarely used since most managers did not see their merit. This stemmed from a belief that although organizational change is unique within institutions, general models and theories do not take into consideration the context or uniqueness of institutions. Hewison (2012) concluded that management time spent on bureaucratic processes associated with health reform needed to be minimized to increase the amount of available time for nurse managers to support frontline staff during periods of organizational change.

Copnell and Bruni (2006) qualitatively explored critical care frontline nurses' experiences of change in an acute-care hospital in Australia between 1996 and 1998. They iterated that organizational change literature did not incorporate health care clinicians' views into change initiatives, thus silencing them. Copnell and Bruni (2006) found that organizational change greatly impacted how nurses understood their work and their subjectivity. Nurses' experiences were in stark contrast to mainstream organizational knowledge about how individuals experience organizational change. Nurses' attempts to rectify those experiences and associated feelings perpetually silenced them. Organizational change challenged nurses in numerous ways that were rarely voiced and not readily acknowledged by the nurses. Copnell and Bruni (2006) concluded that organizational change was a complex phenomenon. The relationship between proposed changes and discursive contexts encompassed a multitude of discourses that informed changes heavily mediated by relations of power and discourses of authority. They advocated for research that contextualizes change in ways outside of dominant discursive frameworks and that would engage nurses in discussions about organizational change in their places of work.

### **Organizational Change: Evaluation and Research Practices**

The development, implementation and evaluation of organizational change in health care have typically been grounded in a technocratic perspective (Fulop, Perri & Spurgeon, 2008; Iles & Sutherland, 2001). A technocratic perspective can be understood as task oriented, objective, instrumental, top down, quantitative and measurable (Connolly, 2011). Technocratic perspectives influence how change is measured, how successful change is determined, what individuals or groups of individuals evaluate change and ultimately what types of organizational research are undertaken and what research questions are asked. Most notably in health care research, a technocratic perspective has fostered the use of quantitative methods when researching organizational change. Nurse's experiences of change have been explored minimally. When explored, quantitative methodologies that use outcome measurement tools have been employed to describe only how and when frontline nurses are involved in change initiatives. The quantitative methods employed have included surveys (Bernerth et al., 2011; Kuokkanen et al., 2007), which prove advantageous for their broad scope but yield relatively superficial information, and "rarely probe deeply into human complexities" (Polit & Beck, 2012, p. 265). There is little opportunity to explore in any depth what may be troubling or concerning to organizational members when survey methods are utilized. Concerns brought forth in survey styles of data collection are that often surveys are anonymous and present no opportunity to return to participants in order to better understand the context of their concerns.

Quantitative studies that discussed organizational change have created knowledge about the process of change itself; how people learn new skills and how they adapt their current practices, highlighting the technocratic components of change (Fulop et al., 2008; Orlikowski & Scott, 2008). Nonetheless, Austin and Claassen (2008) noted that, "While people in organizations are able to change, adapt, learn, and unlearn as they find new ways to operate within their workspace, it is important to understand how staff experience change" (p. 332).

A technocratic perspective does not reflect other types of subjective knowledge associated with organizational change, overlooking the complexity of work and importance of human interaction during change (Allan et al., 2014; Austin & Claassen, 2008). Quantitative methods have the potential to overlook complex human components of change (Kuokkanen et al., 2007). The scarcity of health care knowledge reflecting alternative perspectives of change has been associated with the dominant technocratic understanding of change that managerial perspectives and discourses characteristically support (Rankin & Campbell, 2006).

In the literature reviewed, facilitators, barriers and outcomes of organizational change reflect the highly subjective experiences of employees. Yet dominant organizational research methods continue to collect primarily objective data, focusing on program evaluation where quantitative indicators of success or failure are utilized (Iles & Sutherland, 2001; Wall, 2010). Researchers have focused on how organizational change decreases costs and evaluates HCOs financial performance, a primary measure of success. However, they have minimally addressed other impacts associated with change, most notably those associated with staff well-being and work life satisfaction (Bazzoli et al., 2004). This has created a significant knowledge gap in the subjective understanding of organizational change. In recognition of the complexity and fragility of organizational change, authors such as Chen (2016) and Starbuck (2008) have called for the use of more subjective methods in vast areas of organizational research and have discouraged generalizing findings.

Prevailing and dominant business management frameworks currently influencing the kinds of research carried out in health care studies provide the potential means for bias in research agendas and methods (McKee et al., 2008). This was highlighted by DelliFraine and colleagues (2010) in their systematic review of Six Sigma and Lean project outcomes in the health care industry. A unilateral perspective often leaves little or no room for perspectives and discourses beyond those of management (McKee et al., 2008). This unilateral perspective highlights a lack of acknowledgement of frontline staff in the processes and impact of

organizational change, a significant shortcoming of current research and subsequent literature (Alvesson & Deetz, 2000).

Morgan and Spicer (2009) noted that there are a range of actors involved in organizational change, “often with conflicting conceptions of the kind of change process that organizations should undertake” (p. 254). The literature on organizational change reflects the organizational realities of only a small portion of organizational members (Huber et al., 1993; Deetz, 1998). This is often the same body of research that guides change initiatives in organizations (Kuokkanen et al., 2007). Ironically, organizational literature also presents information that demonstrates that change is fragile and dependent upon a multitude of stakeholders (Buchanan & Fitzgerald, 2007). Additionally change initiatives have often failed when the perspectives of certain stakeholders are overlooked in decision-making processes (Buchanan & Fitzgerald, 2007). Elsewhere, Austin and Claassen (2008) asserted that change planning and implementation have been much more successful when all organizational voices are involved.

Conflicting ideas arising from multiple organizational voices foster a “suspicion of the widely-accepted ideas about organizational change” (Morgan & Spicer, 2009, p. 252). Questioning widely accepted ideas about organizational change fosters knowledge that represents those who often remain underrepresented in research (Alvesson & Deetz, 2000). This provides opportunities to understand phenomena from alternative perspectives such as those rooted in critical methodologies. Only one study in the literature reviewed employed a critical perspective – a Foucauldian poststructuralist deconstruction of nurses’ narratives conducted by Copnell and Bruni’s (2006). There is potential to provide new perspectives on rapid and continuous organizational change that can offer unique insights into the challenges facing HCOs when alternative perspectives guide organizational research.

Organizational change is occurring at exponential rates and will continue to do so (Axelsson, 2000; Dickson et al., 2012; Iles & Sutherland, 2001) as HCOs strive to meet the

changing and often expanding needs of patient populations. Current challenges in health care provide researchers with a “renewed willingness” (Morgan & Spicer, 2009, p, 52) to ask important questions and to seek alternative ways of answering them. It is important that this “renewed willingness” focuses on frontline nursing research. In Canada, nurses are the health professionals that provide the most hours of direct patient care (Canadian Institute for Health Information [CIHI], 2016; CNA, 2006; 2009). The majority of frontline nurses provide patient care within hospitals twenty-four hours a day working through shifts of days, evenings, nights and weekends. Because frontline nurses spend the most time working directly with patients, nurses may have unique experiences of organizational change that may not be reflected by health care professionals who do not provide twenty-four-hour care. Nurses will continue to provide the most direct patient care hours during Canada’s forecasted increasingly rapid rates of health care transformations (Daly, 2014; Dickson et al., 2012). Their experiences are of paramount importance in better understanding the complexities of organizational change in HCOs.

Researchers can expand organizational knowledge by conducting research that aims to understand nurses’ subjective experiences with change in the context of change initiatives (Herold et al., 2007; Nord & Jermier, 1994, Rankin & Campbell, 2006). To better understand the complex workings of organizations and the members within them, qualitative inquiry yielding rich and thick description of experience is important (Deetz, 1982). Alvesson & Deetz (2000) suggest that qualitative methods be paired with critical perspectives to advance the interests of underrepresented members of organizations.

Dialogue and knowledge produced by blending qualitative methods and critical perspectives may support the planning and implementation of organizational change in ways that appreciate the complexity of change and better support the well-being of staff members. This type of research is crucial at a time when continuous and rapid change is compounded by the increasing complexities associated with the provision of health care (Dickson et al., 2012).

This doctoral study explores alternative views on the subject of organizational change in health care while examining emergent concepts and phenomena that remain under-researched.

### **Chapter 3: Theoretical Considerations**

#### **Organizational Theory: An Evolving Dichotomy**

A dichotomy of organizational theories exists in the literature. One group of theories have been put forth by the school of managerial science while the other arose from social science (Perrow, 1986; 2002). Managerial science, for the purpose of this study is understood as the principles, discourses and body of knowledge produced by scholars who study the concept of management within organizations, spanning a wide spectrum of disciplines. The dominant theory originating in the early 1900s provided by managerial science understood organizations as mechanical, production centred, rigid and authoritative. As a result, much organizational phenomena have historically been investigated by means of structured instruments often reflecting positivist assumptions about the nature of knowledge (Alvesson & Deetz, 2000; Orlikowski & Baroud, 1991). Positivist organizational studies have tested hypotheses and theories producing quantifiable information and strengthening the ability to predict the nature of organizational phenomena (Alvesson & Deetz, 2000; Orlikowski & Baroud, 1991). The aims of positivist organizational research often include the creation of generalizable information and the development and testing of organizational theories (Knights, 2004). Furthermore, organizational research has primarily focused on roles of management, specifically how they do/ought to manage institutions (including both financial and human capital) and the attainment of desired outcomes (Duberley & Johnson, 2009; Knights, 2004). This historically narrow research focus stemming from managerial science created organizational knowledge that is often representative of only small sub-groups of organizational members, most notably management (Alvesson & Deetz, 2000).

Max Weber (1947), a social theorist who ascribed to the philosophies of Kant and Nietzsche (as cited by Beiser 2011; Gellner 1974), is noted as one of the first to critique managerial science theorists' understandings of organizations, which he articulated thoroughly in, *The Theory of Social and Economic Organization* (1947). As Weber's (1930) work evolved

through the 1930s he continued to challenge the notion that management could and should be the sole voice of leadership. Despite Weber's influential critique and criticisms, managerial science philosophies continue to dominate present day organizational discourses (Reineck, 2007).

Managerial science philosophies have fostered and sought to normalize understandings of organizations as overtly bureaucratic structures (Perrow, 1986; 2002; Weber, 1930). Bureaucratic institutions, such as factories, government agencies, universities and colleges, and HCOs, consist of a hierarchy of authority with a rigid division of labour, formalization and specialization with written and inflexible policies and procedures, and a continuous quest for efficiency (Perrow, 1986; 2002). Bureaucratic practices define the way in which organizations are structured and how they implement change (Perrow, 1986; 2002). Weber (1968) argued that bureaucratic processes within organizations foster the belief amongst the working class that citizens are unable to live independently or sustain themselves as entrepreneurs, and that they must rely on work provided by someone else harboured within a larger social structure. These beliefs fostered a dependency on organizations for the majority of the population. Beyond this, little was said about workers or their lives within organizations until the industrial revolution.

During the industrial revolution workers sought the means to have voice in their workplaces in terms of organized reforms. This often took the form of unionization (Perrow, 1986). A historical overview is important in highlighting the emergence of power as an influential concept engrained in the earliest conceptions of organizations. The literature review notes that power remains a prominent concept in contemporary organizations and significantly impacts the experience of organizational change (Barrett, 1983; 1989; Espedal, 2017; Fugate et al., 2012; Hertting et al., 2003; Hunter, 2008; Jones et al., 2008; Kuokkanen et al., 2007; Learmonth, 2008; Pfeffer, 1981; Tholdy Doncevic et al., 1998). This strong historical relationship between power and organizations is why I chose to explore power as a central concept in the experience of organizational change.

It was not until the late 1930s that organizations were understood by some, most notably Chester Barnard (1938), as employee-centred, adaptive, responsive, with the potential for being democratic institutions. Barnard's understanding of organizations was rarely referred to in scholarship or research prior to the 1970s, and was first used within the social science disciplines that began to study human relations within organizations (Perrow, 1986). This social science stream of organizational research was highly contradictive of managerial sciences often offering strong critique of organizational practices and the subsequent inequities they fostered. Historically, when change initiatives failed or were unsustainable, it was believed that workers were not maximizing productivity or working optimally, thereby laying blame on employees (Perrow, 1986). Blaming frontline workers for failed change initiative remains evident in today's organizations (Elrod & Tippet, 2002; Merron, 1993). In addition to shaping the understanding of organizations and workers, managerial sciences have significantly shaped the historical construction of the concept of work.

### **The Concept of Work**

According to critical management scholars many changes within an organization including institutional and individual identity, norms and values, priorities and leadership styles are embedded within broader societal change process (Böhm, 2005; Morgan & Spicer, 2009). Society therefore plays a significant role in shaping experiences of individuals' organizational lives. A key area of interest for critical management studies is capitalism. Ways in which society is increasingly governed by the capitalist structure drives organizational change within institutions (Morgan & Spicer, 2009). Capitalism has conceptualized work as something reliant on production and consumption; shaped by discipline, division, class and control, something politicized (Fleming & Mandarini, 2009). Of particular interest for CMS scholars is how capitalism drives "the adoption of new organizational structures, and new technologies" (Morgan & Spicer, 2009, p. 258).

Nursing work has too become embedded within a health care discourse of capitalism and bureaucracy (Rudge, 2011; 2013; Rudge, Holmes & Perron, 2011), where nursing work is “harnessed for health care efficiencies” (Rankin, 2009, p. 275). There is debate as to whether work as conceptualized above may be abstracted from life, whereby critical management scholars Fleming & Mandarini (2009) argue, “the phenomena of work cannot be disentangled from broader questions of identity and dominant discourses that frame the self and his/her life project” (p. 335). I assert this statement to be true specifically as it applies to health care where the characteristics of nurses’ work are intertwined with the human condition. Nursing is a profession charged with emotion that cannot be separated from a life outside of work (Campbell, 2000). In addition, nurses’ personal and professional identities often merge which, according to Fagerberg (2004), means the notion of work becomes a political issue. Conceptualization of work life that is interwoven into life outside of work is important when seeking to understand nurses’ experiences within their places of work. Nurses’ work life experiences directly impact their work life satisfaction, quality of life (Sarafis et al., 2016; Sherman, 2004) and perceptions of self (Adib-Hajbaghery, Khamechian & Masoodi Alavi, 2012; Hensel, 2011).

Nurses’ work is situated action where material and social circumstances mediate every course of action (Campbell, 2000). Nurses’ work cannot often be pre-planned because in health care settings unexpected events happen frequently requiring timely and decisive interventions by nurses. No nursing action, be it the structuring of care or nursing tasks to be completed for a shift, can be fully planned (Campbell, 2000). Yet, nurses’ work is often conceptualized in the managerial science literature as task oriented or technocratic, with task completion driving efficiency and effectiveness of health care delivery (Campbell, 2000; Campbell & Jackson, 1992; Jackson, 1994; Rankin & Campbell, 2006). The term technocratic is understood as work that is task oriented, objective and instrumental, and is work that can most often be measurement with quantitative tools (Connolly, 2011). This type of task-oriented understanding of nurses’ work and the ways in which information about nurses’ work are collected, such as

checklists of task completion per shift, does not accurately portray nurses' work (Campbell, 2000; Rankin & Campbell, 2006).

The problem with technocratic understandings of nurses' work is the removal of the subject from work; the separation of knowing from action (Campbell, 2000). Technocratic understandings devalue and downplay not only the complexity of nursing work but also the importance of the vast kinds of nursing knowledge within health care. Technocratic ideas and assumptions about nurses' work shape what kinds of nursing knowledge are valued and devalued in HCOs (Sandelowski, 2000). Often it is managerial science discourses within HCOs that conceptualize what aspects of nursing work are valued and which are not. Discourses shape what becomes taken-for-granted as the truth about the nature of nurses' work and directly shapes nurses' perceptions of their reality, subjectivity and identity. Theoretical frameworks that explore reality, subjectivity and identity within organizations are timely and relevant in the quest for better understandings of nurses' work in the context of organizational lives.

### **Critical Management Studies**

A Critical Management Studies [CMS] theoretical framework that is grounded in critical social theory (Scherer, 2009) was chosen to guide this study because scholars using CMS are concerned with the role of dominant discourse and practices in organizations, specifically, how dominant discourses and practices can foster and result in relationships of inequity power and to a lesser extent, voice. CMS scholars recognize that dominant discourses and practices within organizations predominantly emerge from knowledge informed by managerial science. They speculate what ought to be done within organizations to address inequity by investigating "asymmetrical power relations within organizational settings" (Foster & Wiebe, 2010, p. 271). The aim of such investigations is to offer a "unique type of assistance in tackling the irreducible complexity of organizational life" (Czarniawaks & Joerges, 1995, p. 174). CMS theoretically guides scholars by the philosophical assumption that organizations are socially constructed

social arrangements where any form of changes within organizations require a process of social reconstruction by all those inhabiting the social structure (Seo & Creed, 2002).

A CMS theoretical framework enables discussion about frontline nurses' experience of rapid and continuous organizational change in "very different ways, relating its practices and institutional arrangements to wider socio-economic and political circumstances" (Hopwood, 2009, p. 516). This challenges the prevailing understandings and practices in HCOs and the dominant discourses that created them. Exploration of frontline nurses' experiences using this framework provides an alternative voice that remains grossly underrepresented in current organizational scholarship (Wall, 2010). By offering an alternative voice, we may come to know and understand differently and speak about phenomena in new ways, ways that enable alternative linkages between phenomena, concepts, theory and practice.

Hopwood (2009) suggested that research affiliated with CMS creates a sense of unease in the world; not an unease that lays blame or intimidates, but rather that challenges certain taken-for-granted understandings of our world. This study challenges the taken-for-granted assumption that all changes, specifically those that are rapid and continuous in nature, are experienced positively and benefit all individuals within HCOs. Further, this research offers new ways of understanding organizational change through a critical analysis of nurses' experience of those changes.

### **Philosophical Assumptions about the Nature of Organizations**

CMS perceives organizations as highly political and social environments (Alvesson & Willmott, 1996). Blindness to these social and political contexts "restricts awareness of how the human difficulties and challenges associated with organizing everyday tasks are compounded by major social divisions that manifest in different values, objectives and resources, and clashes of interest" (Alvesson & Willmott, 1996, p. 20). Such divisions are fuelled by historical organizational discourses that have strong administrative components privileging the voice of management (Alvesson & Deetz, 2000; Putnman, 1983; Redding, 1985). Critical management

scholarship is “committed to issues of voice, that is, opening discursive spaces for those who have been marginalized by or left out of dominant discourse” (Tyrell, 1998, p. 323). It is fitting that CMS opens a discursive space for the voices of nurses.

Philosophical underpinnings of phenomenology (e.g., Husserl), hermeneutics (e.g., Gadamer), poststructuralism (e.g., Foucault), deconstructivism (e.g., Deluze), feminist theory and critical realism have all influenced the development of CMS (Alvesson & Deetz, 1996; 2000; Grey & Willmott, 2005; Klikauer, 2015). CMS scholarship, however, has been most influenced by critical social theory (Adorno, 1976; Foucault, 1980; Habermas, 1985; Horkheimer, 1937; Marcuse, 1968) and is described broadly as “a socio-philosophical school of thought” (Scherer, 2009, p. 30).

Critical social theory analyzes social conditions, critiques the unjustified use of power and works to change established social traditions and institutions so that humans may work to free themselves “from dependency, subordination and suppression” (Scherer, 2009, p. 31). Scholars of critical social theory assert that phenomena are meaningful in subjective ways, are socially constructed and are mediated directly by human understanding (Adorno 1976; Habermas 1985; Horkheimer, 1937). Critical social theory builds upon interpretive understandings of social phenomena created through subjective and interpretive inquiry in order to foster critical reflection (Alvesson & Deetz, 1996; 2000). The influence of the Frankfurt School of Critical Theory is evident in the ideals, goals and values that CMS supports and encourages. For example, Frankfurt scholar Horkheimer (1937) articulated that social patterns are embedded within cultural and historical conditions and that any social analyses put forth are also embedded within those same cultural and historical contexts. These cultural and historical contexts become relevant when researchers explore organizational life and position themselves as researchers within these processes (Alvesson & Deetz, 1996; 2000).

In accordance with these influences, CMS is grounded in the belief that the historical situation of events and/or practices is imperative in understanding the influence of social

systems on creating power imbalances and thus inequities within organizations (Foster & Wiebe, 2010; Rowlinson, Stager Jacques & Booth, 2009). The body of CMS scholarship demonstrates that by historically situating events and phenomena the researcher has heightened awareness of inconsistencies across time, providing an enhanced ability to identify inherent problems with specific social systems (Rowlinson et al., 2009). This in turn better equips researchers to explore multiple ways and resources to advocate for changes to those social systems (Foster & Wiebe, 2010). Historical understandings of organizations are invaluable when organizational studies set out to provide critical reflection in ways that “inform alternative debate between alternative visions of organizations” (Jacques, 1996, p.1).

Initially, CMS scholarship was influenced by Karl Marx but through historical understandings and further interest in the development of work and labor scholarship, CMS expanded to include the philosophical works of Max Weber, Jürgen Habermas and Michel Foucault. This expansion is reflected in the diverse ways in which CMS is currently utilized to guide organizational research and the broad topics of inquiry emerging from the school of thought. This expansion of thought into other critical social scholars has inevitably divided CMS, creating differing theoretical and philosophical convictions. A significance divide in the shaping of this study is the tension that exists between the thinking of Karl Marx and Michel Foucault. Taking the time to recognize and discuss this tension provided clarity for use of the philosophical guidance of Foucault over Marx in the exploration of nurses’ experiences of rapid and continuous change in HCOs.

Tension exists between Marx’s Labour Process Theory and Foucault’s poststructuralist perspectives particularly in the different kinds of research valued and conducted. Research grounded in Marx’s labour process theory examines the labour process itself, that is the “act of working” (as cited by Fleming & Mandarini, 2009, p. 336). Such research is grounded in critical realism where structures enabling and/or constraining social production are the object of inquiry. Marxist inspired research often criticizes poststructuralist research approaches that seek to

explore the contexts of what work means and the ambiguous meanings that inform people's understandings of work.

The emphasis that poststructuralist scholars place on discourse is criticized for its focus on the ramifications of organizational discourses on everyday working lives (Fleming & Mandarini, 2009). In addition, the definitive difference between Marx and Foucault has been their polarity in conceptualizing power. As Knights (2009) articulated, "Foucault has provided critical organizational analysis with an alternative to the mainly Marxist views of power as an oppressive force to be eradicated" (p. 156). This definitive difference in the conceptualization of power greatly influenced my decision to use Foucault's theoretical perspective.

### **Foucault's Influence on CMS Development**

Power is a concept of critical importance for those interested in organizational analysis (Alvesson & Deetz, 2000; Kearins, 1996; Knight, 2009). It is within social structures that hierarchies evolve and practices become embedded in day-to-day living. These social hierarchies and practices become saturated with power. Both psychological and political conceptions locate power within individuals, be it through individual or collective actions. Such notions fail to acknowledge that individuals are products of power located within social hierarchies and practices that produce discourses that are power laden. Power then becomes a relationship between social structures and individuals. What is missing from managerial scholarship and associated perspectives of power is the recognition of the role of agency and subjectivity in the production and maintenance of relations of power. There is a paucity of research within managerial science literature, particularly within HCOs, that has examined how power is exercised in social settings (Kearins, 1996; Knights, 2009).

Historically, power has been understood as "a thing without considering that it must also be a property of relations" (Clegg, 1989, p. 190). It was not until the emergence of social science research that sensitivity to the idea of culture and individuals within organizations began to enter organizational discourses (Clegg, 1989). What emerged were new understandings of

power, ones that moved away from Marx's structural and functional understandings to more pluralistic conceptualizations. A significant contribution to this re-conceptualization of power came from scholars within CMS who were strongly influenced by the works of Foucault. Foucault's conceptualizations of power and subjectivity have been credited with providing frameworks that facilitate the re-examination of and reinterpretation of organizational life (Knights, 2009).

Foucault's work addressed this gap in organizational research and has been widely accepted among critical management scholars. Foucault recognized that intricate web-like relations of power exist between societal discourse and practices and individuals embedded within such discourses and practices. This produces individuals as both subjects and agents. He analyzed the relationships between knowledge, truth and power. He explored how power operates to see the world and produce certain truths within a society that shape how individuals construct their identity within discourses and practices.

According to Foucault (1980) power is never owned; it is neither a commodity nor a status of wealth. Rather it is a circulating, never-ending chain in which individuals simultaneously exercise power and are under its influence. Foucault theorized power as not only oppressive, but a productive force, one in which power "produces concepts, ideas and the structures of institutions" (Foucault, 1977, p. 195). Power is necessary to mobilize and to create change.

In the context of organizational change, exertion alone will not create change; however, organizational change reshapes power systems and relationships (Morgan & Spice, 2009). Power is positive and negative, productive and destructive, supportive and constraining (Knights, 2009). According to Foucault (1977), power is not knowledge; however, power and knowledge can never be separated. When power is exercised it not only draws on existing knowledge it stimulates knowledge development (Knights, 2009). Power does not act or exert itself on pre-existing relationships between sovereign and subject, nor is it the result of

relationships but rather, it is the “productive cause” of relationships (McHoul & Grace, 1993, p. 65). Processes of power within HCOs are complexly impacted by societal and structural elements of health care environments (Kuokkanen et al., 2007). To better understand nurses’ experiences of organizational change, the complex processes of power must be explored taking these elements into account.

Voice is an integral element of power. Many of the ways in which voice has been conceptualized in this study reflects Foucault’s later works. The fundamental importance of voice for Foucault is the way in which it shows conflict between voices embedded in relationships (Siisiäinen, 2012). Voice provides a way of sharing one’s identity and articulating one’s truths. Voice is how individuals speak of their unique truths, which are created by the plurality and multitude of one’s voice in relation to self, other, culture, society and history. Although voice emanates from an individual, it is a reflection of the relationships between self and a multitude of agents. These relationships often exist in tension, which greatly influences how we experience being in the world. Voice is both an object and agent of power and oppression. It is political because the ways it is given and received facilitate the struggle over knowledge. Voice reflects the limits and possibilities of knowledge and speaks to the tension between governed and governing (Foucault, 1980). Voice is moral in that it often represents vulnerability and a loss of sovereignty and self-sufficiency. Voices may become muffled when they seem threatening from the point of view of a governing discourse (Siisiäinen, 2012).

### **Reality, Subjectivity and Identity**

CMS asserts that truth is value laden and can never be value free. Peoples’ realities are shaped by subjective experiences. Organizational reality is a direct result of social construction (Berger & Luckmann, 1964) and is neither “casually [n]or objectively determined” (Scherer, 2009, p. 38). Poststructuralist scholars in CMS believe in multiple truths that change over time (Fournier & Grey, 2000). Brown (1978) highlighted the constructive and subjective nature of research grounded in CSM, where objectivity is unattainable and undesirable. Amidst such

social construction is the concept of subjectivity, understood as how individuals construct their unique organizational reality. Foucault (1984) understood subjectivity as a direct product of culture and power constructed by human relationships that are embedded with power and present in all societies. Subjectivity is endlessly produced by individuals, organizations, discourses, interpretations and contingencies in response to cultural and historical contexts (Mansfield, 2000). Individuals are in constant evolution managing the influences that knowledge/power exert over the subject (Foucault, 1980). Here, subjectivity is understood as a means of freedom; acting as both a precursor to, and a product of, governmentality and power relations. Individuals have the capacity to resist multiple influences of power by means of exerting their own forms of power. It is these fluid and dynamic power relations that foster subjectivity as something that is never fixed and always under construction (Knights, 2009).

Subjectivity in organizations is strongly influenced by an organization's attempt to create certain role identities, for example, manager, executive, leader, or client/consumer. Attempts to create role identities are accomplished by means of specific discourses and techniques of governance that work to connect an individual's organizational identity with the goals and values of an organization (Thomas, 2009). The ability of individuals to exert their own power as proposed by Foucault (1984), that is, to act as active agents, creates the opportunity for individuals to counter such influences. Foucault (1979) however also recognized that institutions always have some degree of influence and that individuals may be unaware of such influence. This understanding of subjectivity has been widely adapted by CMS and used in the theoretical grounding of a great deal of critical management research.

CMS scholars articulate that beyond organizational identity there exists a greater, socially constructed identity that influences an organization's identity. CMS considers individuals to be active in the construction and reconstruction of an organization's identity resulting in positioning of the self "within managerial inspired discourses" (Alvesson & Willmott, 2002, p. 629). This conception of subjectivity reflects a Foucauldian perspective of power, a conception

that is productive, supportive and positive, as opposed to oppressive, constraining and negative (Foucault, 1984).

Identity is understood as allegiances, beliefs and traits individuals possess, giving way to a unique personality and mode of social being (Hall, 2004). Subjectivity, an extension of identity, includes self-consciousness and awareness of the many elements that influence and shape an individual's identity. Subjectivity also questions where and how an individual's identity has been constructed and to what extent individuals control their identity. Identity and subjectivity are of interest to CMS because the concepts offer a means of exploring and critiquing exclusionary practices within organizations (Thomas, 2009).

With specific regard to the exploration of nurse identity within HCOs, Paliadelis and Cruickshank (2008) found that even nurses who possess a strong nursing identity felt unheard in HCOs and felt excluded from decision-making processes. This qualitative finding links the concepts of voice, power, identity and decision making and supports the exploration of how these theoretical concepts are interwoven into organizational life during periods of rapid and continuous change. Paying attention to identity construction in this study allowed for the exploration of exclusionary practices in organizations that may have directly contributed to certain knowledge becoming devalued or silenced (Foucault, 1979).

Individual identity in organizations is constructed by means of social interactions as influenced by institutional ways of being and knowing (Thomas, 2009). This conceptualization is important for this study as it focuses on power relations within organizations. An individual's identity within an organization is fluid and always capable of changing. It is often relations of power within organizations that are responsible for identities that both change and stay the same over time. In HCOs, identity construction reflects the position of an employee "within managerially inspired discourses" (Alvesson & Willmott, 2002, p. 629).

Identity construction is intentional and involves choice, whereby an individual acts as an active agent, or, as expressed by Thomas (2009) "thinking subject possessive of intentional

actions” (p. 168). For example, when an individual chooses to accept or reject certain discourses, the act of making a choice reflects an act of power. Choices made as acts of power are central to identity construction (Thomas, 2009). Bergström and Knights (2006) describe identity as the outcome of interaction between human agency and discourses rather than as being determined by one or the other. Discourse acts as both a resource for identity construction and a constraint. Individuals are influenced by discourses when attempting to shape their identities yet have the agency to decide how to let such discourses influence their identity construction (Thomas, 2009).

### **Poststructuralism in CMS**

Poststructuralism emerged in response to structuralism in France during the 1960s and 1970s, at about the same time CMS was emerging as a school of thought in response to the vast amount of managerial science dominating organizational discourses (Jones, 2009). It was influential in shaping CMS and the work its scholars carry out (Jones, 2009). Poststructuralism in CMS has been credited with encouraging critical scholars to overcome the subject versus structure dualism that is so strongly apparent in predominant understandings of organizations (Jones, 2009) and with bringing the subject back into organizations. Nevertheless, as Jones (2009) articulated, more often than not the actual conceptualizations of the subject remain ambiguous and poorly explained in critical management scholarship.

Certain streams of CMS, particularly those using a poststructuralist framework, study organizations and the people within them for political reasons (Jones, 2009), offering “strategies that allow a rethinking of both identity and social determination” (Gibson-Graham, 2006, p. 25) to foster critical reflection. The purpose of critique offered by the poststructuralist stream of CMS is to foster ways of knowing that differ from the assumptions of managerial discourse (Jones, 2009). Critical reflection is important in facilitating the exploration of discourses and ways of knowing that, through discursive influence and organizational practices, may become what Foucault (1979) described as disqualified knowledge. Poststructuralist critical managerial

perspectives provide researchers with the opportunity to explore this idea in depth through qualitative inquiry.

Poststructuralism in CMS acknowledges the influence of organizational culture in shaping organizational life. Poststructuralist perspectives in critical management scholarship provided an opportunity to “break away from the restrictive functionalism that prevails in management literature” (Jones, 2009, p. 78). A prevailing functionalist approach in management literature focuses on outcome and evaluation rather than the processes and people within organizations (Mercer & Flynn, 2017). Historically in organizational research, poststructuralist questioning of the roles of discourses and representation have offered insight into, and challenged the way in which, frontline staff in organizations have been conditioned into certain ways of being and certain types of organizational roles (Westwood & Linstead, 2001). The concept of organizational discourse is of importance in this study as a component of the way in which organizational change is framed, discussed, initialized and carried out through various discursive means.

Poststructuralism in CMS has been credited with creating heightened awareness of, and sensitivity to, the researcher’s role in critical organizational research (Fournier & Grey, 2000). A poststructuralist approach to knowledge development recognizes that knowledge is co-created by the participant and researcher. Such co-creation is dependent upon an individual’s unique experiences that are framed within social and political contexts and shape knowledge construction (Duval & Berés, 2011). Although the research participants’ unique experiences are valuable components of knowledge construction, the unique worldviews that shape the researcher’s interpretation of knowledge creation must also be made explicit and reflected upon throughout the research process to ensure transparency (Fournier & Grey, 2000).

### **The Need for CMS in Health Care Research**

Organizations operate by means of rules and laws that are knowingly and purposefully created by human action (Benson, 1977). Organizational rules and laws create social structures

that condition individuals to accept roles assigned to them (Marcuse, 1964). Such roles have been articulated and construed in ways that often do not foster critical reflection. Approaches taken by managerial science suggest organizations govern by means of reified values and beliefs where individuals within organizations remain “ignorant to potential forces driving individual behaviour” (Scherer, 2009, p. 38). Scholars of CMS envision organizations that “create workplaces that are more humane, establishing new forms of participation that help workers to preserve their autonomy and to find alternatives to the bureaucratic model” (Alvesson, 1985, p. 124). Holmes (1992) suggests that creating organizational dialogue with underrepresented groups, who are not encouraged to engage in critical reflection at the organizational level, will foster critique that will result in the creation of institution and structures that exemplify principles of freedom, equality and justice (Markovic, 1974). Critical scholarship serves to offer “critique of the present, a vision of the future, and a means by which theory and practice could unite in the realisation of that vision” (Holmes & Warelou, 2007, p. 177).

The call for novel critical social scholarship that further explores the roles of nurses in HCOs has been made (Thurlow, 2007; Wall, 2010). Furthermore, the analysis of subjectivity, identity and relations of power through a CMS lens is helpful in exploring the tensions that may exist between the “who are we” and the “who am I” in organizational identity construction. Tension is integral to this study as nurses’ experiences of organizational change are both dependent upon, and reflective of, this tension of identities. Organizational discourses influence and reflect the power/knowledge relations that mediate the construction of an individual’s identity within the organization. CMS is a theoretical framework fostering unique organizational research that provides an understanding of frontline nurses’ work lives amidst rapid and continuous organizational change. It will provide a unique opportunity for knowledge acquisition in the discipline of nursing.

## **Chapter 4: Methodological Considerations**

No consensus exists within CMS on ontology and epistemology; indeed, such differences may well prompt different methodological choices (Jeanes & Huzzard, 2014, p. 232).

### **Knowledge Construction within Organizations**

Despite the increased use of qualitative methodologies such as hermeneutic and critical studies that enable a constructivist approach to inquiry (Knights, 2004), there is little research involving HCOs that use a CMS theoretical framework. The rising number of research studies in organizational scholarship that have used a hermeneutic paradigm is welcomed. Hermeneutics is broadly understood as a means of inquiry that focuses on meaning and interpretation of lived experiences with the purpose of exploring how “individuals interpret their world within their given context” (Polit & Beck, 2012, p. 490). Hermeneutic research has been described as a means to better understand the status quo (Orlikowski & Baroud, 1991).

Certain perspectives may not be represented within a pure hermeneutic orientation to inquiry. Four areas of importance to contemporary critical social research are argued to be missing (Fay's, 1987). First, hermeneutic methodologies may fail to acknowledge or recognize the external (social or historical) conditions that produce certain meanings from lived experience. Second, they may not explore the consequences, intended or not, of certain social actions. Third, hermeneutic research alone does not explore conflict within organizations or the larger social systems in which they function. Fourth, hermeneutic research designs do not take into account changes in society over time. What is missing is the exploration of how particular social orders have come to be and the limitations and possibilities of what that means for social orders both in the present and future.

When hermeneutic inquiry is combined with a critical lens, for example, as offered by critical social theory, critical hermeneutic research additionally seeks to challenge the status quo by critiquing social systems and practices to reveal inherent contradictions and conflicts within

these systems (Orlikowski & Baroud, 1991). Conducting critical hermeneutic research within organizations fosters a deeper understanding and self-consciousness of certain social conditions (Alvesson & Deetz, 2000) and in doing so creates the capacity to challenge certain taken-for-granted social systems and practices (Orlikowski & Baroud, 1991).

Questioning of taken-for-granted assumptions is of fundamental importance to a critical social theory researcher. Steffy and Grimes (1986) argued that the basic role of critical social theory in organizational science is to investigate the dynamic and complex interplay of the social structures of organizations and produce knowledge that reflects the relations between “research, theory, technology, practice, praxis and ideology” (p. 328). Alvesson and Deetz (2000), CMS scholars, support Steffy and Grimes’ assertions and advocate for the use of many critical methodologies to meet the aims of critical organizational scholarship.

Using critical methodologies in organizational studies makes strange the things in organizations that become institutionalized in various ways (Deetz, 1982), noting that that which becomes institutionalized often becomes taken-for-granted (Alvesson & Deetz, 2000). Critical methodologies analyze taken-for-granted assumptions and institutionalized practices and explore alternative perspectives and recognize the existence of pervasive power relations within organizations and their impact on an individual’s organizational life. Frost (1980) describes the purpose of critical methodologies, what he calls a radical framework for organizational science, as one that “ought to work consciously toward expanding our repertoire of organizational perspectives, to try and understand how others in organizational arenas perceive and construct their realities” (p. 504).

“Expanding the repertoire of organizational perspectives” (Frost, 1980, p. 504) is done by turning to other organizational members or groups that are not well represented in research. Emphasis is placed on better understanding what under-represented groups within organizations find problematic and taken-for-granted (Frost, 1980). Subsequent knowledge has the potential to strengthen organizations. Recognizing multiple perspectives within organizations

challenges individuals to think differently about organizational practices including policies and procedures, change initiatives and decision-making processes.

Critical social philosophy embraces the idea of totality wherein nothing may ever exist as an isolated element (Orlikowski & Baroud, 1991). Things (in the philosophical context of an object, being or entity) only exist “in the context of the totality of relationships of which it is a part...and are bound by interdependence” (p. 19). Things are dependent upon both social and historical conditions (Orlikowski & Baroud, 1991). When change is conceptualized from this critical perspective it is not an isolated event. Rather, it exists only in the context of relationships to other things, within both historical and social conditions. For example, change is productive only in the contexts of social relationships that deem it productive. Change cannot be studied independently of its historical and institutional situations.

### **A Multidimensional Approach to Research Methodology**

Denzin and Lincoln (2000) introduced the concept of bricolage into qualitative research discussions adapting the term from the French anthropologist Levi-Strauss, who discussed the bricolage in *The Savage Mind* (1966). Historically, the French word bricoleur was used to describe handywomen and handymen who utilized tools from tool kits to complete their work. For Levi-Strauss (1966) the savage mind was the person who constructed things using whatever materials were at hand. Denzin and Lincoln described the bricolage as a multi-method mode of conducting qualitative research that challenges researchers to reach beyond standardized methods of inquiry to innovatively stimulate unique knowledge development.

Kincheloe (2001; 2005) crafted a bricolage to reflect a critical orientation using Denzin and Lincoln’s conceptualization. According to Kincheloe and McLaren (1998), critical social theory’s contributions to modern day society have yet to be fully understood or utilized in contemporary research. To move forward and explore the vast conceptual terrain that critical theory may offer researchers and the potential for unique knowledge development requires a toolbox approach to conducting research (Kincheloe & McLaren, 1998). Kincheloe (2001; 2005)

calls this toolbox approach a critical bricolage. Kincheloe's interpretation of a critical bricolage is built upon an acute awareness of the relationship between power and knowledge. Kincheloe (2005) supports Foucault's (1980) conceptualization of power as both oppressive and productive and embedded in discursive practices that shape what can be said, by whom, and what kinds of knowledge may be created, legitimized or ignored (Foucault, 1980).

The critical researcher who uses a bricolage approach to research is described by Kincheloe (2001; 2005) as a bricoleur. The bricoleur is one who "moves beyond the blinds of particular disciplines and peers through a conceptual window to a new world of research and knowledge production" (Kincheloe, 2005, p. 323). In addition, the critical bricoleur's role is to seek out and explore power relations embedded within discursive practices to better understand and make known how power relations mediate who can speak and what can be said in certain situations (Kincheloe, 2005). Kincheloe's thinking aligns strongly with many critical management scholars (Alvesson & Deetz, 2000, Knights, 2004; 2009, Perrow, 1986; 2002) in that his conceptualization of a critical bricolage is grounded in an epistemology of complexity and criticality. For Kincheloe (2005), the role of the bricoleur is to deconstruct the complexities of social theory; understood as cultural and linguistic and where interpretation is inseparable from historical contexts. CMS scholars, particularly, Alvesson and Deetz (2000) offer guidelines for methodological decision making which are not prescriptive in nature, articulating that methods are determined individually, are evolutionary in nature and respectful of the contextual nature of qualitative inquiry. A critical bricolage design should incorporate a multimethodological, multitheoretical and multidisciplinary informed approach to methodological decision-making and should be interdisciplinary at philosophical, epistemological, ontological and methodological levels (Kincheloe, 2001; 2005). Innovative knowledge is gained by utilizing analytical frameworks from outside the chosen discipline of inquiry (Kincheloe, 2005), such as the application of analytic frameworks derived from CMS to inform the discipline of nursing.

The aforementioned methodological approach presented an opportunity to build a unique bricolage that facilitated the exploration of organizational change as experienced by frontline nurses and as mediated by the concepts of power and voice. Kincheloe's conceptualization of interdisciplinarity supported the decision to use critical management studies [CMS] to explore the phenomena of change with HCOs and bring CMS into nursing scholarship in a way that uniquely contributed to both organizational and nursing knowledge. Kincheloe's (2005) complex web-like understanding of the interplay between philosophy, epistemology, ontology, and methodology recognizes that theoretical frameworks may also offer methodological guidance and can further be utilized in conjunction with other methods. However, Kincheloe (2005) warns that eclectic methodological decision-making must still demonstrate "theoretical coherence and epistemological innovation" (p. 324). Utilizing a bricolage framework requires both reflexive practice and strong philosophical, theoretical and methodological knowledge:

As one labors to expose the various structures that covertly shape one's own and other scholars' research narratives, the bricolage highlights the relationship between a researcher's ways of seeing and the social location of his or her personal history.

Appreciating research as a power-driven act, the researcher-as-bricoleur abandons the quest for some naïve concept of realism, focusing instead on the clarification of his or her position in the web of reality and the social locations of other researchers and the ways they shape the production and interpretation of knowledge (Kincheloe, 2005, p. 324).

Critical hermeneutic researchers seek to recount the experiences of a phenomenon, that is, how people perceive, understand and act in relation to that phenomena (Orlikowski & Baroud, 1991) and to understand and critique the circumstances within the social world that create inequity and constraint. The researchers chosen theoretical framework informs their understandings and critiques (Brown & Gilligan, 1992; Orlikowski & Baroud, 1991). Critical social methodologies used in critiquing organizational practices extend and complement hermeneutic analysis with the addition of a critique of ideology (Steffy & Grimes, 1986). West et

al. (2012) remind critical researchers that it is within ideologies that certain forms of knowledge are produced, reproduced and presented in ways that sustain relations of power and inequalities which continue to marginalize certain groups of society.

CMS challenges the status quo within organizations by problematizing certain practices and ideologies. Challenging the status quo is done by exploring situations and phenomena that are often taken-for-granted within organizations. Critical management scholarship has accomplished its aims by methods including critical ethnography, critical hermeneutic studies, and critical discourse analysis (Alvesson & Deetz, 2000).

## **Methods**

### **Research Design**

This critical research study was grounded in a CMS framework and employed critical hermeneutics. Commensurate with the concept of critical bricolage (Kincheloe & McLaren, 1998, Kincheloe, 2001; 2005), I used and adapted the qualitative research methods developed for critical research studies in organizational change research, notably the works of Alvesson and Deetz (2000) in combination with another school of thought proposed by Brown and Gilligan (1992).

Alvesson and Deetz (2000), established academics in CMS, specifically inspired me by their text entitled, *Doing Critical Management Research*. Their non-prescriptive discussions of methods guided the site selection, sample, interview space and interview techniques for this study. Exploring the concepts of power within organizations and organizational practices make apparent taken-for-granted situations and phenomena and facilitates and stimulates critique (Alvesson & Deetz, 2000). One of the most important roles of critical hermeneutic work is to bring forth “weak, hidden, obscured and peripheral voices and discourses...and a variety of empirically grounded discourses, such as local actors voices on subject matter” (Alvesson & Deetz, 2000, p. 152). Methods employed for this study utilized the voices of nurses as a means to critically explore the experience of rapid and continuous organizational change.

Although Alvesson and Deetz (2000) offer a broad range of critical hermeneutic data analysis methods, none facilitated the in-depth exploration voice through lived experience sought for this study. The data analysis method that best facilitated the exploration voice in the organizational context of this study was Brown and Gilligan's (1992) voice-centred relational method of data analysis [VCRMDA]. The VCRMDA is a hermeneutic analysis approach that facilitated the exploration of the embodiment of frontline nurses' experience as it was articulated in association with the self, other, culture, society and history.

Critical hermeneutic work ought to explore how individuals relate to their world, which can be achieved by critically interpreting the account of experience provided by the interviewee (Alvesson & Deetz, 2000). The text that is reflective of a critical hermeneutic study is one that reflects the voices "silenced by dominating corporate practices" (Alvesson & Deetz, 2000, p. 158). The VCRMDA facilitated the exploration of nurses' voices that often remain underrepresented in organizational discourses (Axelsson, 2000; Kuokkanen et al. 2007; Wall, 2010)

Some scholars (Alvesson & Deetz, 2000; Evered & Louis, 1981) have suggested that a dichotomy in organizational research exists where experience is either viewed as unique and non-generalizable or as universal and generalizable. The importance of collective meaning is referred to by Alvesson & Deetz (2000) as "cultural phenomena" (p. 155). Alvesson and Deetz (2000) suggest that critical organizational research should include a level of collective meaning analysis, advocating the existence to some extent of a shared social reality. With the complexities of current organizational life, it is hard to envision that all experience is either exclusively individual or exclusively generalizable. The VCRMDA served to bridge the gap between this dichotomy by exploring experiences as they occurred on both the individual and collective levels. Using the VCRMDA to explore those changing relationships within HCOs as a result of rapid and continuous organizational change provided a way to better understand these changes, offering the alternative perspectives of frontline nurses. Furthermore, VCRMDA

facilitated the exploration and exposure of constructs of power embedded within the working lives of nurses (Paliadelis & Cruickshank, 2008). The VCRMDA enabled exploration of those who speak and also those who listen, thus reflecting the exploration of power relations embedded within discursive patterns (Letvak, 2003). This has the capacity to bring forth voices of individuals or groups often disempowered in society (Proctor, 2001).

Critics of Brown and Gilligan's VCRMDA have argued that from a postmodern perspective one's "self" cannot be deconstructed as fragmented selves (Butler, 1990; 1994). However, I do not conceptualize Brown and Gilligan's analysis method as one that seeks to solely fragment the self. I interpret it as a method that deconstructs the multiple complexities embedded in a plenitude of individual relationships that shape human experience, the purpose of which is to explore and challenge taken-for-granted assumptions by making them visible. Weedon (1987), another critic of the VCRMDA has argued that the concept of "self" is inadequately defined in Brown and Gilligan's method. For the purposes of this study, concepts of subjectivity and identity have been explored and conceptualized extensively in the theoretical framework chapter of this dissertation and have been included as a component of the analysis and discussion.

### **Insider and Outsider Organizational Researchers**

Research that historically shaped organizational knowledge has been predominantly conducted by outsiders (Perrow, 1986). Typically, outsiders are individuals who do not work in the organizations being studied (Alvesson & Deetz, 2000). It has been outsider assumptions that have predominantly guided knowledge development within organizations, subsequently shaping organizational practices and associated roles of organizational members (Alvesson & Deetz, 2000). Research from an outsider perspective involves detachment, neutrality and the assumption that researchers are onlookers. Knowledge is measurable and logical and data is assumed factual and content free, results are universal and generalizable (Evered & Lewis, 1981). Outsider research often overlooks the human components and complexities of

organizational life (Evered & Lewis, 1981), a significant shortcoming of the research to date on organizational change.

In contrast, Kincheloe and McLaren's (1998) place importance on research from an insider's perspective (Evered & Lewis, 1981) or employees as critical researchers. Research from an insider perspective involves researcher presence and immersion and active participation in knowledge creation. From this perspective, knowledge is experiential, data is contextual and open to interpretations, and results are situationally relevant, accounting for human components of organizational phenomena. Findings are not universal and rarely generalizable on a large scale (Alvesson & Deetz, 2000; Evered & Lewis, 1981). It is the insider researcher who, through lived experiences within an organization, has become aware of the complexities and human components of organizational life (Evered & Lewis, 1981).

Kincheloe and McLaren (1998) articulated that insiders who conduct qualitative research are empowered to explore how power operates in shaping their everyday experiences within their workplaces by reflecting upon and interpreting the conditions that define work. In addition, this is where workers participating in critical research studies begin to see how power and privilege shape workforces and workers can then challenge the prevailing organizational discourses. Insider critical researchers seek not only to describe the reality of their work lives, but work to change aspects of their work or restructure their workplace in ways that promote equity, opposing the "instrumental rationality of scientific knowledge" (Kincheloe, & McLaren, 1998 p. 279). Kincheloe and McLaren's (1998) perspective remains relevant in organizational research, as it is frontline workers who remain underrepresented within mainstream organizational literature (Alvesson & Deetz, 2000).

An insider researcher (Evered & Louis, 1981) conducting research in one's own workplace is understood in the literature as practice close research (Lykkeslet & Gjengedal, 2007). Practice close research occurs in a practice area where the researcher has intimate understandings of the organization and/or the participant sample. Conducting practice close

research may increase the risk of the insider researcher taking things for granted or introducing bias. For example, the researcher may have a different relationship with participants because they share commonalities (as nurses and as employees of the same institution), which may lead researchers to feel compelled to present participants' statements in a positive light or to defend them (Lykkeslet & Gjengedal, 2007). Methodological decisions throughout the research process were made in light of these considerations.

### **Setting**

The setting was a single Canadian, urban acute-care pediatric, academic teaching HCO that provided care for patients aged newborn through 18 years of age. The implementation of an electronic charting system amidst the recent and concurrent implementation of new intravenous pumps, medication administration record systems, and medication dispensing cabinets were used as exemplars in order to capture the rapid and continuous organizational change typically noted in HCOs that affect the work lives of frontline nurses (Dzik-Jurasz, 2006; Karsh et al., 2009; Korunka et al., 1997). The units from which nurses were recruited included medical, surgical, oncological, neonatal critical care, pediatric critical care and emergent care services.

### **Participants and Recruitment**

Criterion sampling was utilized, where "all participants must have experienced the phenomena and must be able to articulate what it is like to have lived that experience" (Polit & Beck, 2012, p. 524). The aim of hermeneutic inquiry is to obtain breadth and depth of understanding of a phenomenon as experienced by a unique population providing contextualized understanding through intensive case studies (Koch, 1998). Therefore, I anticipated that I would need 10 to 15 participants to garner the breadth and depth of data necessary to understand frontline nurses' experiences of rapid and continuous organizational change in this acute-care setting (Polit & Beck, 2012).

Frontline registered nurses (RNs) were recruited from only those inpatient units that provided 24hr nursing care, seven days a week. Additionally, frontline nurses from the HCO's

nursing float pool who serviced any of these inpatient units were invited to participate. Frontline nurses had to have at least one year at the participating institution to ensure ample exposure and experience of rapid and continuous organizational change. For the purpose of this study, only those frontline nurses who provided direct patient care and rotated through shifts of days/evenings/nights and weekends were included. This was important in capturing and better understanding rapid and continuous change during those hours when support and resources for change initiatives may be decreased (evenings/nights/weekends). Nurse practitioners were excluded. Since the hospital's working language was English, all participants engaged in the study conversed in English.

Once institutional and University Research Ethics Boards approvals for the study were received (see Appendices A and B), I approached managers of the involved units for their support as well as permission to present the study at staff meetings and to place recruitment posters in designated communication areas. The recruitment posters outlined the study aim, inclusion/exclusion criteria, anticipated time commitments and study dates, as well as researcher contact information (see Appendix C). The Director of Nursing Research at the study site electronically distributed the approved recruitment material (see Appendix D) to all RNs via the internal electronic-mail distribution list. Recruitment ceased when thick, rich and complex data description was obtained and a high degree of redundancy was observed (Polit & Beck, 2012).

Fourteen frontline RNs participated in the study. A socio-demographic questionnaire (see Appendix E) was completed by participants at the commencement of interviews. Participants were predominately female, 13 females, one male. Participants ranged in age from less than 30 years to greater than 50 years. The highest level of education obtained ranged from certified diploma to masters degrees. The areas of practice were evenly distributed, with half in critical care and half in acute care and float pool. The number of years at the institution ranged from 4 to 30. Years on current unit ranged from less than one to 23 years. 7 of the 14

participants were considering leaving their current position, one was considering leaving the profession altogether and none were actively seeking employment elsewhere (i.e., submitting resumes externally).

### **Data Collection**

Intensive, one-on-one, conversational interviews were used as the data collection method to enable frontline nurses' voices to be heard. The interview served to provide a "fuller appreciation of the complexities and difficulties of change" (Granot, Brashear, & Paulo, 2012, p.548), including a deeper appreciation for the issues, structures, processes, and policies that influenced organizational change. The interview also served as a means for each participant to express his or her feelings and to work through emotions that were both positive and negative, "As an employee with limited authority the researcher may be a valuable ally or channel for allowing his/her voice to be heard" (Alvesson & Deetz, 2000, p.155). Furthermore, the interview provided a personal and political space where participants could exercise some level of influence and speak their minds about their organization.

To ensure interviews were participant-centered I did not pre-arrange times or places for the interviews on their behalf. Instead, I informed participants that we needed a private setting so that confidentiality would not be compromised and their interview would not be rushed or interrupted and then negotiated these specifics with each participant. Participants were given the choice of being interviewed during their working hours or on their own time. I outlined the potential challenges of engaging in an interview at work: decreased anonymity should the interview take place at their workplace and diminished engagement in the interview process due to time restrictions away from unit combined with worry about patient care and delegation of workload to others while absent. All participants chose to coordinate the interviews outside of their working hours. Most interviews were conducted at the participants' homes, while several others were held in a confidential office space at the university. Formal consent was obtained at the outset of the interview (See Appendix F).

Each participant engaged in one face-to-face, semi-structured interview, which ranged from 51 to 160 minutes. All interviews were digitally audio-recorded. To create an open and honest interview environment I began each interview with a synopsis of why I was conducting the study, sharing that the desire to conduct the study came out of my own personal nursing experiences of organizational change. Open-ended questions were used to address the research questions guiding this study and covered such topics as the types of changes experienced, how changes were experienced, the impacts of change, levels of involvement in decision making and implementation of changes (see Interview Guide, Appendix G). An open-ended style of questioning captured each participant's stories about his or her experiences of rapid and continuous organizational change in the work place. As well, it facilitated an exploration of the web of relationships that shaped those experiences and, as noted by Granot et al. (2012), a more conscious awareness of the power of the social and organizational context of people's experience. Finally, the use of open-ended questioning acknowledged that I, as an insider researcher, did not assume that I knew what those webs looked like or how others experienced them. Rather, I sought to create a space of exploration where participants could speak openly regarding what was important to them about their experiences, even sharing things I had never conceptualized.

For each open-ended question, I established probing questions in the event that some participants experienced difficulty telling their stories or needed assistance focusing within the broader question. As participants' stories can often convey multiple different thoughts and ideas, I jotted down participants' key words and phrases on a note pad so that I could follow up if I needed greater clarity or more in-depth accounts for some of those ideas that had been lost or that I had misunderstood in their story-telling. This pragmatic structure of the interview with its subsequent probes was guided by Alvesson and Deetz (2000), who stated that "a good interviewer asks few, open ended questions, is patient, empathetic, client centred, has time at

his or her disposal, and promises autonomy” (p.155). This process allowed participants to tell their story with minimal interruptions.

I created field notes immediately after each interview. Field notes provided a detailed account of the interview, including the tone of voice, body language of the participants during parts of their story telling, and interruptions that occurred. Notes also consisted of my own thoughts and feelings about what I heard during the interview and then my reflections on my reactions to certain words or stories and why I did or did not pursue a particular line of questioning. The field notes included my reflections on the similarities and differences in perceptions about the experience of organizational change of those participants previously interviewed.

### **Data Analysis**

Brown and Gilligan’s (1992) VCRMDA was utilized to explore the key concept of voice and offered “a pathway into relationship rather than a fixed framework for interpretation” (p.22). This aligns with the understanding that researcher and participants are co-creators and co-learners that frame this study. The assumptions of the VCRMDA are that our sense of self and the way in which we come to experience the world is “inextricable from our relationships with others, and with the cultures in which we live” (Gilligan et al., 2003, p. 157). The VCRMDA served as a way of attending to the many voices embedded in a person’s expressed experience in a systematic manner (Gilligan et al., 2003). Brown and Gilligan offer levels of analysis that provide means of “interpreting narratives as a way of understanding meaning making processes,” (p. 158).

Language is a portal we use to express our way of being in the world (Gilligan, 1993). The voice we give our experience, the way it is embodied by our histories and our cultures, and how we come to understand those experiences in relation to self and other are of interest to this hermeneutic inquiry. Giving nurses’ voices was a key component of this study. Therefore, a data analysis method that facilitated the exploration of voice was both necessary and appropriate.

The conceptualization of voice provided by Brown and Gilligan (1992) coincides with their goals of feminist psychology research. From this viewpoint, they identified four assumptions regarding voice:

1. Voice is a psychological entity; it is “the associative logic of psyches” (p.19), the “inner psychic world of feelings and thoughts” (p.20), and the “channel of psychological expression” (p.23).
2. Voices are the embodied connection between body and psyche, and culture and psyche (p.20).
3. Voice is understood as the true feminine self, authentically expressing who women really are and what they really feel. Relationships are paramount for the ability to adequately express moral concerns (p.20)
4. Voice is an object of oppression, and can be silenced by more dominant discourse (p.20)

My study was not grounded in a feminist psychology worldview so I used Foucault’s conceptualization of voice accordingly. This was still deemed the most appropriate data analysis method as Brown and Gilligan (1992) too recognize power as a central concept to voice. Adaptation of Brown and Gilligan’s method of data analysis is supported by other nursing scholars (Letvak, 2003; Paliadelis & Cruickshank, 2008; Proctor, 2001). Additionally, because the conceptualization of voice chosen to guide this study was not gendered, both male and female nursing voices were sought, analyzed and interpreted. Such conceptual adaptations of voice have been suggested by Davies (1994) to strengthen Brown and Gilligan’s VCRMDA to reach beyond the confines of feminist inquiry.

I transcribed the audiotaped data immediately following the interviews. Participants and setting information were de-identified at the time of transcription. I was actively immersed in the transcription process for five weeks, actively re-hearing the participants’ stories, making note of the participants’ tone, strength of voice, emotions (e.g., laughter, anger), and length of pauses. I

coded manually; using different coloured pencil crayons and construction paper to represent the relationship to self (pink), other (green), culture (purple), society (blue), and history (red). Underlining the text, “using different coloured pencils for each listening” (Gilligan et al., 2003, p. 159) created an analytical audit trail by rendering my coding highly visible to self and others. It also helped to visualize how the various voices moved in relation to each other. From those original transcripts, I electronically extracted each of the underlined texts, according to their color coding, and compiled them into separate documents for further analysis. Within each participant’s coded transcript, I wrote notes in the margin that corresponded to each significant quote extracted. This process enabled me to identify which relationship in the quote (e.g., self, other, culture, society or history) was dominant and which relationships coexisted and were interdependent or interactive. Each listening and reading was also documented through additional researcher notes and interpretive summaries written during each phase of analysis (Gilligan et al., 2003). I returned to these journaling notes at multiple points throughout the analysis and writing phases. The VCRMDA consist of 4 levels of analysis, which are detailed in the coming pages.

**level one.** The first reading provided a sense of what was being told, what was happening in the participants’ story or telling of experience, the “when, where, why, and with whom” (Gilligan et al., 2003, p, 161). I noted words or phrases that described aspects of each participant’s experiences in a preliminary way. Because premature description is “one of the potential dangers” (Morse & Richards, 2002, p. 148) of hermeneutic research, I simply took note of these word and phrases and returned to them after all first readings were completed and throughout each level of the analysis.

Qualitative hermeneutic studies are highly dependent on the use of one’s “personal historical background” (Rapport, 2005, p. 134). The first reading helped me situate within participants’ stories, to reflect upon my own social location in relation to the participants’ and to concentrate on my response to the use of their language. This reflexive process was done

through a writing summary, which signified the beginnings of a relationship with the text and speaks to the importance of reflexivity in qualitative research (Alvesson & Deetz, 2000; Alvesson & Sköldberg, 2000). Writing reflections was imperative to understand how I pre-understood participants experiences based on my own. My responses enabled me to minimize what Alvesson and Deetz (2000) call “hyper critique” (p.182), that is, the situation wherein critical researchers may gravitate towards unbalanced negativity or positivity and one dimensionality.

**level two.** The second level of analysis explored how each participant spoke of self. It focused on the “I” in the narratives, it’s use represents how the participant understood and knew the self. Additionally, focusing on the “I” helped me enter into a unique relationship with individual texts, to prevent the tendency to designate the participants as “other” and to create distance between myself and the participants, thus potentially objectifying them (Brown & Gilligan, 1992). This second level of analysis speaks to the importance of subjectivity, identity construction and the understanding of self, all central concepts to CMS (Alvesson & Deetz, 2000). Exploring how participants understood themselves helped me understand their relations to others and broader social systems.

I engaged in a line-by-line deconstruction of the participants’ stories, as recommended by Brown and Gilligan (1992). I underlined the word “I” and any other seemingly important words and phrases in the transcript related to the relationship with self and then electronically copied them into another document for further analysis. The creation of new documents facilitated the exploration of statements not always made directly, but which could be central to understanding. This idea of discovering and finding meaning in words, both apparent and unapparent, is central to interpretative research (van Manen, 1997).

**level three.** The third level of analysis explored how participants spoke of interpersonal relationship between self and other. Distinguishing what relationships were of significance was guided by the chosen theoretical framework (CMS), as per Gilligan et al.’s (2003) directive.

These pre-determined relationships included nurse in relation to colleagues, managers, other leadership, patients and their families, and technology. Since, technology drives much of the change in HCOs, I chose to include animate and inanimate objects in the other category. This decision was informed by the understandings of technology embedded within CMS, where technology is understood to be influential in the identity construction of employees. I also intentionally searched for other significant relationships revealed by the participants. Analytical questions regarding the relationships between voices were informed by CMS and included those that addressed relations of power. The following questions, generated by Gilligan et al. (2003), were used during this third level of analysis: Does one voice compete over another? Do they oppose each other? How do these voices influence how the “I” has created meaning of experience? Gilligan et al. (2003) described this form of listening to voices as an iterative process.

**level four.** The fourth level of analysis explored voice in relation to broader cultural, social and historical contexts. This level of analysis explored how participants created meaning of their experiences of rapid and continuous organizational change based on their relationships to culture, society and history. This was crucial because sociocultural and historical traditions exercise power that mediate ways of being (Alvesson & Deetz, 2000). Trigger words described by participants that signified sociocultural and historical contexts included; “the culture of nursing”, “the way it is”, “the way it used to be”, “the younger generation”, “gender”. Participants referred to the impact of changing social landscapes on healthcare delivery, the evolving educational and practice requirements of nurses, the need for more men in the nursing profession and suggested these ideas reflected sociocultural and historical contexts.

After re-reading all transcripts I created a written summary of potential themes that emerged from all participants. I circled key words and phrases in all transcripts, then extracted and compared them to the preliminary themes I had noted in the first level of analysis. I re-explored the initial themes and dismissed those that I believed were no longer applicable. I

provided supportive rationale for both those that were dismissed and those that had been created from more in-depth analysis at subsequent levels. This final set of themes was verified by my academic supervisor and kept as part of the audit trail. Remaining themes were organized under the broader thematic categories of self in relation to self, other, culture, society and history. Preliminary categorized themes were then disseminated to my committee members along with a partial set of de-identified clean copies of the full transcripts for committee member verification. Once I received approval and feedback from the members, thematic analysis continued.

At that point, electronically compiled phrases that had been underlined using the pre-established color-coding system for self, other, society, history and culture were printed, cut, and manually glued to coinciding colored construction paper. These extracted phrases were re-analyzed for sub-themes. At each level of analysis, I moved between the parts of each participant's data and the participant's entire original transcript to ensure that I had not taken a "part" out of its original context in a way that altered the participant's intended meaning and to better understand the whole of the experience.

### **Assurance of Quality Research**

To assure scholarly quality of this study, I was guided by Watson and Girard's (2004) concept of integrity, which is grounded in three criteria of quality related to qualitative research methodologies: wholeness, honesty and soundness. In addition, I was directed by the concept of transformative re-definition as discussed by Alvesson and Deetz (2000).

#### **Integrity**

Watson's and Girard's (2004) beliefs regarding integrity in qualitative research arose from Gadamer's (1989) assertion that to believe understanding emanates from rigorous implementation of methods is to miss the point of human experience. Neither form nor context is central to experience, "rather it is the meaning of the experience that is important" (Watson & Girard, p. 877). How can researchers engaged in hermeneutic inquiry then determine if the

meaning of experience has been adequately understood? Without relying on quantitatively driven concepts, Watson and Girard argued that integrity is an appropriate way to ensure experience has been adequately understood and portrayed. Assurance of scholarly research was further enhanced using insights provided by Alvesson & Deetz (2000). Such insight was used in an effort to maintain the integrity of the philosophical, epistemological and ontological assumptions of CMS. These insights included enhancement of thick description and the prevention of “hyper-critique” (Alvesson and Deetz, 2000, p 182), whereby critical researchers may gravitate towards unbalanced negativity and one dimensionality. Thick description and prevention of hyper-critique were achieved using teamwork and member reflections, which occurred during the analysis phase to explore thematic development and ensure accurate portrayals of experience.

Regardless of the level of engagement with reflexive processes, it would be naïve to expect to understand and represent a multitude of worldviews independently. The use of teamwork in hermeneutic inquiry is important when conducting in-depth analysis to garner an understanding of participants’ experiences (Cohen, Kahn & Steeves, 2000). The unique and differing worldviews and preconceptions of the thesis committee members and participants were used to richly and comprehensively understand the phenomenon of change as experienced by nurses. Committee members were given the opportunity to review and discuss transcripts at every level of analysis and the preliminary interpretations were returned to committee members for feedback and further direction before moving onto subsequent levels.

Understanding that “no interpretation is ever complete, no explication of meaning is ever final, no insight is beyond challenge” (van Manen, 1997, p. 237), the goal of data analysis was to provide rich description and interpretation in the form of written text. The understanding of thick description that was most fitting for this study is that provided by Denzin (1989), noting the importance of context, social relationships and voice:

A thick description...does more than record what a person is doing. It goes beyond mere fact and surface appearances. It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard (p. 83).

The researcher/researched nexus created throughout the research process drove thick description. The attainment of thick, rich description occurred at the interview process level and was attained by the use of open-ended questions, asking participants to share their stories, the use of timely probes, and creating a trusting atmosphere where participants felt comfortable sharing and did not feel rushed or judged.

Thick description was verified by teamwork and member reflections. This occurred when each participant's experience was richly and deeply described; as agreed upon by myself, academic supervisor, committee members, and participants who chose to engage in member reflections. The last draft of interpretative analysis was compiled into an eight-page summary of findings that was distributed to participants (via their preferred email as identified on consent forms) to determine if the themes accurately reflected their experiences and the portrayal of their voices. Participants were given the option to engage in a follow up interview to offer other interpretations and ideas that may have been overlooked prior to the final writing process. Although no participants chose to engage in a follow up interview, they followed up with gratitude on email, noting that the findings resonated with them and accurately captured their experience.

**wholeness.** Watson and Girard (2004) describe wholeness as a researcher's capacity to have a broad view when exploring a phenomenon, that is, to look beyond the phenomenon in the specific context in which it is being studied. The researcher must find a way to move

between the parts of individual participant's experiences and the broader social and cultural context in which those experiences occur. The challenge for the researcher is to ensure individuals are not lost within the broader social and culture contexts of phenomena. The researcher must find balance between individual experiences of phenomena and "cultural phenomena" (Alvesson & Deetz, 2000. p.155). I ensured this criterion was met by utilizing an extensive method of data analysis that supported constant iteration of multiple levels of analysis.

Wholeness is demonstrated when the researchers can openly acknowledge how their preconceptions and prejudgements will mediate how they make sense of human experience (Watson & Girard, 2004) and how they represent both individual experiences of phenomena and "cultural phenomena" (Alvesson & Deetz, 2000, p. 155). Without this fusion of researcher and researched and the recognition that their unique lived experiences meld into a co-created understanding of experience, wholeness will never be achieved (Watson & Girard, 2004). Wholeness was enhanced by acknowledging my experiences with rapid and continuous organizational change and sharing my epistemological stance pre-study. Reflective journaling throughout the study and discussions and debates with my academic supervisor and committee members helped me recognize this ongoing engagement with experienced qualitative researchers as a growing and learning opportunity.

**honesty.** Honesty in qualitative research is a process, one that is carried out not only in the interview, but also throughout analysis and interpretation (Watson & Girard, 2004). Only when there is openness in the approach to fostering dialogue will individuals be able to honestly share their stories of experience (Watson & Girard, 2004). Researchers must be honest with themselves and participants about their pre-understandings and the ways in which they will mediate understanding of participants' stories of experience. These pre-understandings must be explored prior to entering into dialogue with participants and the transcribed texts of experience. Honesty was made visible through reflexive journaling done at all phases of the research

process. I briefly shared my experiences of rapid and continuous organizational change as part of the introduction to this study at the outset of each interview and with the readers.

I conducted the study in my own workplace, which as noted previously is understood as practice close research. Lykkeslet and Gjengedal (2007) spoke of the challenges of explicating researcher preconceptions in practice close research. Nonetheless, I argue it is impossible to understand a phenomenon without preconceived notions. What is imperative in practice close research is the capacity to be reflexive, that is, to identify preconceived notions at the onset of a study and to engage with those assumptions for the entirety of the project. A reflexive methodology was maintained throughout this study that built upon a journal started in 2011 when this research study came to fruition. As noted by van Manen (2006), writing as a method begins long before a research project commences. It is often through writing and other methods of reflexivity that research questions come to fruition. For this reason, I chose to include and build upon the aforementioned journal throughout this study. Consistently engaging with a process of reflexivity ensured participant statements were not presented in a certain light or defended solely based on my preconceptions and biases - noted challenges of critical research (Alvesson & Deetz, 2000). Representations were the result of intensive analysis and reflexivity, heavily supported by the academic supervisor and thesis committee.

**soundness.** Soundness is reflected in the way research findings are disseminated, both written and oral (Watson & Girard, 2004). To demonstrate soundness, research writings cannot be constructed in a way that the parts become severed from the whole; parts can never be fully understood alone (Watson & Girard, 2004). The purpose of a written research report is to relay experience to the reader in a way that they may engage in some level of emotional response (Garratt & Hodkinson, 1998). This was done initially through the development of the member reflection document. Soundness became the guiding criterion of integrity when writing the subsequent findings and discussion chapters. I related nurses' experiences through accurate portrayal of their voices in my writing. I projected participants' voices in a way that will engage

readers in an emotional experience and will heighten their awareness of nurses' experiences. Emotionally engaging readers will stimulate them to think differently and perhaps more openly about the impact of rapid and continuous organizational change on the lives of frontline nurses.

### **Transformative Re-definition**

Critical scholarship is criticized for its grandiose claims to emancipatory acts such as freeing the oppressed and creating large scale equalities (Fleming & Mandarin, 2009). Grandiose emancipatory claims do not seem viable given the complexity of HCOs and the small homogenous sample of this study. Rather, I envision the contributions of the study as a form of micro-level emancipation that will stimulate some degree of "transformative re-definition" (Alvesson & Deetz, 2000, p.151)

HCOs are complex webs of people, discourses and relations of power created from a multitude of personal histories, values and beliefs. Organizational practices reflect those complex histories. Over time certain practices become institutionalized and taken-for-granted and become difficult to change. Alvesson and Deetz (2000) asserted that creating knowledge that represents alternative perspectives often would not stimulate drastic change. Alternative perspectives can, however, lead to better understandings of an organizational phenomenon and create opportunities to act in slightly different or more productive ways (Alvesson & Deetz). A realistic aim for this study, then, was, to create what Alvesson and Deetz (2000) describe as transformative re-definition.

Transformative re-definition in critical analysis attempts five aims. The first aim is to encourage development of competing discourses. I have accomplished this by providing a counter narrative reflecting participants' experiences. The second aim is to embrace constructive conflict. I embraced the conflict that exists between managerialism and nursing knowledge and truth claims revealed by the participants. This conflict takes the forefront of much of this dissertation and any future dissemination of findings. The third aim is to participate in agenda setting. In the future research section of this dissertation, I have clearly articulated

one possible agenda required to move the discourse forward. The fourth aim is to participate in reality definition by providing alternative accounts of organizational reality. I have accomplished this by providing raw data to highlight nurses' accounts of organizational reality which often differed from those found in main stream organizational research. The fifth and final aim is to participate in decision-making. Much of the implications section of this dissertation meets this aim. This section clearly articulates the ways in which participants believed change should be instigated and implemented, and suggests who should participate in organizational change decision-making. Nurses' recommendations will be distributed to key stakeholders at the participating HCO, which includes frontline nurses (by way of presenting at nursing research rounds and various other council groups within the organization), the Director of Nursing Research & Knowledge Translation, Chief Nurse Executive, Director of Nursing Practice and the Chief Executive Officer. In addition, findings will be published in peer-reviewed journals and presented at conferences to ensure the discourse is ongoing and evolving. Through transformative re-definition there is hope that this study's writings, presentations and publications will challenge individuals to reconsider the ways in which organizations instigate rapid and continuous organizational change and challenge taken-for-granted assumptions about organizational change.

The quality of critical research is not solely based on the ability to tell a good story, but on the ability to participate in human struggle – “a struggle that is not always vicious or visible but a struggle that is always present” (Putnam 1983, p. 227). At first glance Putnam's (1983) assertion is in a stark contradiction to Watson and Girard's (2004) assertion that storytelling is how quality research is created. This depends on how one interprets the goals of storytelling. Watson and Girard (2004) suggested a story should act as a median to stimulate emotion. Evoking emotional responses has the potential to bring humility to alternative discourses presented in research writings. Through evoking emotion in the reader, alternative discourses representing “disqualified knowledge” (Foucault, 1979, p.21) are given consideration and are

reflected upon. Evoking emotion does not serve to create rigor, as the concept of rigor “has no place in CMS research” (Fleming & Mandarin, p. 333), but rather it serves to create scholarly research.

### **Ethics**

Ethics approval was obtained from the University of Ottawa Health Sciences and Science and participating HCO’s Research Ethics Boards. All agency and administrative requirements were completed appropriately and in a timely manner in order to obtain access to participants. All paper data (e.g., signed consent forms, transcripts, field notes, journals and audit trails) were stored in a locked cabinet in my advisor’s locked office at the university. All signed consent forms (Appendix F) were stored separately from the interview transcripts to ensure confidentiality. Participants were assigned number codes as identifiers at the time of transcription; names were never documented on data. Digital recordings were kept on an encrypted USB stick. All signed consent forms were stored separately from the interview transcripts to ensure confidentiality. All dissemination and communiqué regarding this study (writings, presentations and publications) will use female pronouns for all participants in order to protect the anonymity of the one male participant. Additionally, all hospital and colleague identifiers were removed from the transcripts and replaced with generic signifiers in brackets, such as [physician name]. Similarly, specific “isms” of the hospital were replaced with generic nursing vocabulary throughout transcripts. For example, the term charge nurse replaced the unique name the institution had assigned this nursing role. Only de-identified data was shared with my academic supervisor and committee members.

I believe that any inquiry asking an individual to share personal experiences and associated emotions constitutes sensitive research. Therefore, participants were reminded that they were free to refuse to answer any questions, to ask that the recorder be turned off or to end the interview at any time. Participants were expected to share only the information they were comfortable disclosing. Should participants have experienced distress, I was prepared to have

stopped the interview and assist them with contacting their employee assistance program should they have so wished.

Ethics reaches far beyond receiving ethical clearance to conduct research. To become an ethical critical organizational researcher one must reflect upon his or her own practices and reconceptualize ethics to include, “reciprocity, positionality, responsibility, and attention to voice” (Wray-Bliss, 2009, p. 280). Ethics becomes a relationship between participants, the organizations where research is conducted, and all of those potentially impacted or influenced by the dissemination of research findings. I was attentive to and mindful of Wray-Bliss’s (2009) conceptualization of ethics throughout the research process. I demonstrated high levels of reflexivity throughout this project to make evident the thoughtfulness of the many decisions that were made throughout the research process. I acknowledged the challenges associated with conducting critical research as at some point my role as a critical researcher was to critique and challenge certain practices and discourses as they unfolded through the participants’ discourses about organizational change.

Conducting critical research ethically involves ensuring fair and just representation (Mantzoukas, 2004) of participants’ voices. I made every effort to ensure nurses’ voices and experiences did not get lost through the writing, rewriting and dissemination processes associated with research. I did this by continuous and mindful practices of reflexivity and through the engagement of my academic supervisor, thesis committee and research participants in the analytic, interpretative and writing phases of this study.

## **Chapter 5 Findings: A description of the Nature of Change**

### **Methodological Notes on Individual and Collective Voice**

Interestingly, the data shows that nurses did not solely speak as first person, but shifted their discourse to also reflect a collective nursing narrative. Whilst I analyzed each individual transcript to tease out participants' relations to self, other, culture, society and history, what emerged was interconnectedness to a collective voice. This finding suggests that an individual's voice cannot exclusively be treated in isolation because it draws on a collective voice that shares contextual meaning and sense making.

Participants discursively mediated the use of, "I", the individual nurse (as their own subject), "we", the collective group of nurses, "you", inclusive of what appeared to be a less intimate or unknown "we", such as frontline nursing groups in general, and "they", which always applied to leadership personnel throughout their narratives. Participants at times positioned themselves speaking as part of a collective to bridge the gap between individual and collective subjectivities. They did this by generalizing challenges in their work related to rapid and continuous change as a widespread concern throughout their institution and amongst all nursing staff. Participants generalized feelings of frustration, anger, cynicism and distrust, all of which appear to dominate the emotional repercussions of experiencing rapid and continuous change found in the data. The "we" voice they created strengthened the individual voice to give credibility or validation to individual experiences. This served as an important contextual strategy where, according to participants, nurses' subjective experiences were the object of frequent contestation and dismissal. Special consideration must be made regarding nurses' experiences but also to the forms of expression used by nurses. Their expressions provide insight into how they made sense of their experiences, how they communicated such meanings, and how they strengthened the credibility of their claims.

There were assumptions embedded in participants' use of a collective "we" and "you". For example, they described a kind of caring disposition that all nurses necessarily share, which

was used to articulate nurses' concerns regarding rapid and continuous change. Participants tended to narrate a personal experience with the use of "I", and often went on to state that others had experienced the same things, thus enrolling their colleagues and all frontline nurses (and their voices) into a collective, seemingly homogeneous narrative. For example, one participant recalled that upon requesting to be compensated for overtime work she had to "sit down with the charge nurse and explain what you could have done differently... and have a meeting with your manager", she extrapolated the situation by using "you", (participant 7, line 273-275), instead of "I". In addition, there was the assumption that the person speaking spoke with credibility and legitimacy on behalf of a larger group of nurses. In doing so, there was a certain quality and confidence given to that voice. I questioned where this certainty came from throughout the analysis process, and also the ways in which participants portrayed themselves as speakers and presented themselves to me, the researcher. I believe there was political action and agency mediating the discursive patterns participants used. Participants conveyed a general understanding that nurses' position and status in their workplace needed to be problematized. The interview context provided them with an opportunity to convey this problematization.

Often individual voices represented a collection of voices that were not individually identified, but assumed by participants. Two important examples emerged from the data. The first example depicts two participants who articulated generalized statements about gender, to the effect of nursing being a female dominated profession; women were less able to cope with change in comparison to men, "I just don't think they [men] are as emotionally led as women...I never saw any of them [men] getting upset to the same degree as the female staff...they just don't fuss about changes in the same way we do" (participant 1, line 1459-1466). It was suggested that if nursing were a male dominated profession, nurses would not passively accept the many cited change initiatives and would have a more powerful collective voice, "I think if it was the other way around some of this stuff wouldn't be implemented at all because the guys

would have just stood up and said no that's not happening" (participant 1, line 1472-1474). The male participant however, described the same experiences of perceived powerlessness and voicelessness during change initiatives. Using one's voice to generalize about gender in the nursing profession, as seen here, bears implications that may include the perpetuation of negative stereotypes (e.g. nursing being a powerless and voiceless profession because of its female dominance) while rendering invisible the experiences of particular individuals or groups (in this case, male nurses).

The second example I present, is that none of the participants made mention of nurses who may not have agreed with their views, or may have had positive experiences of change. This reinforces the appearance of a consensus about nurses' experience of rapid and continuous change in that particular hospital. Yet, managers may have heard both negative and positive experiences from nursing staff, which may offset the perception of change as being primarily damaging to nurses and their work.

In both examples, the collective "we" can strengthen the claims being made. It can also conceal diverse perceptions of change or work to silence certain voices. "We" can also undermine the credibility of nurses whose account of the situation can be deemed deviant from the seemingly homogenous narrative constructed by participants. Participants exclusively referred to all levels of leadership (senior executives and nursing unit managers) as "they", which appeared to create an "us versus them" narrative, which sets the stage for much of the seemingly mutually exclusive discourses that arise in the findings.

Another interesting discursive pattern emerged from the data. Participants at times downplayed their work and their voice. For example, participant 5 described the ways in which nurses learn as "monkey see, monkey do" (line 89) and participant 9 described nursing work as "shit" that nobody but nurses understands, "nobody gets this shit [nursing work]" (participant 9, line 604-605). The ways in which some nurses spoke in their interviews at times also downplayed the power of their voice. This is an important finding as it may contribute to their

feelings of perceived voicelessness and silencing. Some nurses undermined their own voice by nuancing and tempering their concerns and their experiences. The following quote illustrates this process:

It's *probably* with your personal life too, I think it *probably* has to do with that too. When you *feel* like you need *a bit more* energy for yourself, and you need to give a lot at work too, and it *just feels* like there's nothing ...it *just feels* like too much. It certainly doesn't help when you're being pushed *a bit* with crazy patient loads... I *think* you get exhausted (participant 14, line 669-680). [Italics added]

Through the choice of words, this participant seems hesitant and speaks as though she is downplaying the weight of her observations. She also removes some of the focus off the problems associated with change initiatives and appears to blame her personal life for some of the issues, suggesting some degree of internalization of systemic problems. Another participant similarly internalized blame and fault for issues she had argued earlier in the interview were organizational issues:

...Why, at midnight, am I worried about it? Well it's my unit, I have to face it in the morning...well and *maybe I took on too much*. But you know *you can't help it* (participant 8, line 804-815). [Italics added]

When I examined participants' word choices more closely, the appearance of personal doubt became visible in their recountings of rapid and continuous change. For example, the italicized words in the following quotes reflect the presence of doubt:

*Perhaps it's just me* on particular shifts I was working on, but *it seems* to be that the workload is increasing (participant 7, line 270-271). [Italics added]

We're not practicing holistic nursing *I find, maybe* everyone else is and *it's just me* (participant 10, line 109-110). [Italics added]

I mean, *it might just be my experiences*, but I haven't found a good avenue yet (to voice concerns) (participant 11, line 725). [Italics added]

All participants shared strikingly similar concerns regarding the issues discussed by these 3 participants: increasing workloads, loss of holistic nursing care and the inability to voice nursing concerns regarding change initiatives. The watering down of the significance of nurses' concerns by participants is noteworthy. Nurses need to be able to articulate their voice in ways that reach the person they are speaking to, but nurses' speech may be counterproductive if it does not reflect their rational analysis of the situation. There was significant frustration and anger within the data, but the ways in which some nurses nuanced their voice reduced those emotions. Participants were adamant they had important and valid concerns, and they used concrete examples of the negative impacts of change initiatives to validate their concerns. However, some of their narratives contained speech devices that weakened their message and may have rendered it less convincing for those in management and leadership positions, who held power over nurses' current work conditions and were the decision makers regarding change initiatives.

### **Characteristics of Rapid and Continuous Organizational Change**

Participants revealed eight characteristics of rapid and continuous change. These included multiple types of change initiatives which were rapid and continuous in nature with concurrent implementation and exponential change (that begat more change). Communication patterns changed as result of changes, change was top-down and externally and internally driven. Changes were hasty in nature and resulted in anticipated and unanticipated consequences.

First, participants noted different types of change in their place of work. Many of those changes impacted multiple disciplines, departments and services across the organization. Examples included the implementation of the documentation component of an electronic health record, introduction of intravenous smart pumps and medication administration cabinets, organizational administrative restructuring and changes to staffing practices. Other changes were unit-based or nursing specific. These included a restructuring of frontline nursing positions

and the care delivery system, which involved alterations in the types of health care providers employed. There were subsequent nursing lay-offs, unit amalgamations, the introduction of a new nursing model of care and the standardization of multiple nursing practices. Participants experienced living through high turnover rates of their frontline nursing colleagues as well as revolving personnel at the middle, senior and executive nursing leadership levels, “Organizationally there’s been a lot of movement with managers and charge nurses and changing of the hierarchy” (participant 14, line 11-12).

Second, participants described the pace of change as rapid, non-stop, often repetitive and occurring over many months and years. As participant 8 expressed, “It has been years and years of change for all staff. It just hasn’t stopped and we just haven’t gotten our feet back underneath us” (line 8). Paradoxically, those participants who had been long-term employees noted that “the institution went from years of never ever, ever changing anything to completely changing everything every 6 months or faster” (participant 12, line 186-188). The ongoing nature of change as experienced by these nurses lead to feeling overwhelmed:

Changes are coming one after the other and you’ve got to deal with it on a daily basis.

It’s hard...there’s only so much you can absorb. There’s only so much you can learn...there’s a level at which sometimes it’s overwhelming (participant 1, line 448-695).

Third, it was not uncommon for two or more major HCO change initiatives to occur concurrently because they were rolled out simultaneously and/or were overlapping: “At that time everything was rolling out, new intravenous pumps, electronic documentation system, new equipment, new structure of nursing, new way of doing rounds, everything came in at that time” (participant 8, line 17-19). These concurrent initiatives included large-scale alterations that required significant adaptations to nursing workflow. As noted by participant 14, “here was big changes, a lot of big changes happening at once” (line 23). Change participants experienced was exponential. That is, change beget change. A single HCO change initiative resulted in multiple micro level changes. For instance, the introduction of intravenous smart pumps

required new compatible equipment supplies, numerous and continuous technology updates and the addition of new policies and procedures associated with fluid administration.

Participants noted that many recent change initiatives required additional change initiatives to rectify unanticipated problems. For instance, soon after the hospital wide implementation of the new smart intravenous pump, ongoing issues with these pumps required they be totally replaced: “We have to change pumps again...you’re looking at, in less that 6 years, 2 pump changes, that’s a huge amount of change” (participant 13, line 554-556). In addition, the electronic documentation system required “multiple upgrades” (participant 4, line 8), with participant 10 noting that, “after a few years of these different programs [electronic documentation software] we’re scrapping all of them and getting a new program” (participant 10, line 489-490).

“A huge change in your workflow and...how you practice” (participant 13, line 556-557) also accompanied many changes. Nurses needed to learn new cognitive models and shift their cognitive decision making to adapt to workflow changes, “it [medication cabinet implementation] was a whole new way of learning and working” (participant 13, line 577). Participants experienced many workload redistribution alterations a result of the various change initiatives including the allocation of many nursing tasks to other regulated or non-regulated health professionals. One nurse, referring to the reallocation of medication reconstitution and preparation to the hospitals pharmacy, described the work redistribution as “taking us [nurses] out of our role, that was part of our job” (participant 8, line 32). Participants also made note of policy and procedural change initiatives that accompanied new change initiatives. The following quote illustrates the policy change initiative that occurred with the reallocation of medication reconstitution and preparation initiative combined with the implementation of the medication cabinet: “You had 30 minutes before...and after in which to give medications and all of the sudden it became an hour before and an hour after ...Where is that change coming from?” (participant 13, line 586).

Fourth, participants described interprofessional communication pattern alterations, both in how team members communicated patient care needs and delivery and how change initiatives were communicated to frontline staff. Participant 13 provided the following example of how interprofessional communication regarding patient care shifted following the implementation of the electronic documentation system: “They [doctors] don’t know where to look for [patient] information...Before they used to be able to read our nursing notes and they’d know exactly what’s happening with the patient...now there’s so many places to look; there’s no central place for them to get a snapshot of the patient” (line 520-528).

Other participants lamented that rapid and continuous change resulted in a “constant” and “tiring” (participant 8, line 792) barrage of daily emails from all levels of the leadership groups since it had become the primary communication strategy. Participant 7 expressed this in the following way: “We get a million emails; we get so many emails everyday...flooded with them” (line 181-183).

Fifth, rapid, continuous change was predominantly from a top-down direction. Participants acknowledged they were not involved in identifying change initiatives at the organizational level and did not “really know if the other staff were really consulted” (participant 1, line 64-67); rather, senior administrators “just basically did it and gave us an email” (participant 3, line 585); “We were not involved in that decision, that was a much higher level discussion above those nurses who would be impacted by it” (participant 9, line 207-208). It was noted that this style of decision making was common throughout the organization: “There’s too much very top heavy decision making going on and very little bottom up control” (participant 9, line 1395-1396)..

Sixth, nurses noted that rapid and continuous change was externally and internally motivated. There were three external forces identified. One was accreditation [e.g. “I know they’ve [implemented specific change] for accreditation. I understand that” (participant 12, line 214-215)]. The second related to government funding pressures, such as the expectation to

deliver a zero-based budget with no increase or reductions to funding despite rising costs [e.g., “[The hospital] is way over budget and the government has not increased our funding so in order to bridge that gap they’re going to be eliminating [nursing jobs] at the hospital” (participant 7, line 214-216).]. The third external factor concerned the public’s expectation for timely care delivery [e.g. “She [a nurse] starts her day with 11 people [patients/families] yelling at her that the wait time is ridiculous” ( participant 9, line 263).].

Internal forces that drove change initiatives included the idea of “catching up” after neglecting to making needed changes, and additional changes required to accommodate planned changes (as described above). As a point of illustration, participant 12 hypothesized that one of the reasons for rapid and continuous change was as a result of the organization’s new leadership striving to make up for the lack of new initiatives during the tenure of his predecessor:

It wasn’t like that before. I think we got a new [executive leader] and the one before didn’t want changes and this new one does, and promotes change and he’s doing everything that should have been done years ago all in one shot (line 245-252).

Seventh, change resulted in anticipated and unanticipated consequences, both desired and undesired. Nurses saw beneficial changes, “I see the positive impact [of some of the changes]” (participant 4, line 519), but noted that the rapid and continuous nature of changes also made it “hard sometimes to process all this change when...there’s so much demand put on your time” (participant 4, line 520). Participants described how changes increased their workloads, “every time they’ve [leadership] changed something we’ve said, ‘this is increasing our [nurses] workload’...it’s [electronic charting] a massive addition to the workload” (participant 10, line 178-185). Regarding a specific change implemented to reduce inefficiencies, participant 9 noted, “I think we eliminated a lot of inefficiencies and I think we got much better at doing our jobs” (line 202), however that change had unforeseen consequences, “we built such a fast and effective system. If you build it they [patients] will come, and as a result our volumes have

doubled and our nursing staff have not” (participant 9, line 202-232). Participant 9 reflected upon the irony of establishing a well oiled-machine. On one hand, a fast and efficient system initially enhances productivity and promotes patient and family satisfaction with care and may even promote some cost savings. On the other hand, this high level of productivity can only be sustained if the necessary human resources are provided to meet the increased productivity achieved, in this case, an increased volume of patients served in a timely manner. When the HCO failed to respond to this outcome, nurses no longer perceived a congruence between nurses’ and HCO’s goals for organizational change.

The last characteristic of rapid and continuous change was that it was considered hasty. Hasty meant implementation without much thinking or due process, “slamming [multiple changes] it all at once and hoping it flies” (participant 11, line 873). It was considered reactionary in nature in that, “instead of [change] being proactive, it’s reactive a lot of the time” (participant 14, line 480-481). When asked to provide examples of the reactive nature of change, participant 14 recalled both the electronic documentation systems and the intravenous pumps, stating, “Instead of being proactive and getting a product that was more suited to the nurses, the workflow... we’ve just gone with the cheapest and then react to how it doesn’t fit into the environment” (line 483-486).

### **Discordance in Ideological Orientations to Change**

“All the decisions appear to be very budget driven as opposed to patient care driven” (participant 10, line 8).

Underlying participant’s perceptions of the purpose of change was a significant discordance between what they believed should guide change and what guided the organization’s decisions regarding change. The purpose of rapid and continuous change was understood to be associated with fiscal concerns, including resource management that often resulted in cuts in nursing service and numerous other measures to increase efficiency. Change initiatives were understood as supporting a new culture of service. Participants, in contrast,

sought change that supported “good”, “safe”, “quality”, “family-centred” and “holistic care” delivery that reflected a traditional culture of care. A culture of service and a culture of care were perceived to be mutually exclusive, meaning that to provide one, the other must be sacrificed. The mutual exclusivity of these cultural ideologies contributed to the discordance experienced. Participants also described at length the multiple phases of change, which they understood in terms of assessment and planning, implementation and evaluation, and leadership and communication styles.

### **Culture of Service**

Change is more driven by corporate goals than nursing needs (participant 7, line 290).

A culture of service was often associated with “streamlining” (participant 8, line 497), “standardization” (participant 13, line 90), “budget” (participant 10, line 41), “money” (participant 1, line 300) and the “bottom line” (participant 4, line 472). This service model appeared to prioritize these items over nurses well-being and quality patient care delivery. All participants felt that organizational priorities driven by efficiency for the purpose of balancing the budget fostered a culture of service. There was a perception that the push for a zero-based balanced budget created a culture that did not support care, but rather supported a timely and efficient service delivery system within profit-driven businesses. Participants described an environment where “there’s a huge amount of pressure on nurses to sacrifice caring for these patients and start moving them along [quickly through the health care system]” (participant 9, line 81-82). This created a workplace where, “They [leadership] really aren’t fostering care, they’re fostering service. It’s a different thing” (participant 9, line 1064-1066).

Ultimately, participants perceived this (mis)alignment of priorities as a lack of concern for employees, “They [leadership], don’t care about us as people at all. It’s money, money, money, that’s their bottom line” (participant 6, line 282). Placement of priorities left nurses feeling as though they were “dispensable” (participant 6, line 316) and “expendable, disposable” (participant 9, line 1305). Participants alluded to a culture of service reflected by leadership

trying to “impose a business model in healthcare” (participant 13, line 30), which was perceived as transforming hospitals into “big, big business” (participant 9, line 1102). A key component of a service driven culture was the increasing use of technology to carry out activities (to improve efficiency), that were historically done by health care staff “there’s more technology...it’s less people processing things and more machines” (participant 4, line 495-496). The exponential implementation of technology was accompanied by perceptions that technology was valued over people, “it’s newer technology so it’s got to be better [than nurses]” (participant 6, line 138):

So what’s more important here? The machine is more important than a person is, the ultimate message that gets dribbled down [from leadership to staff] (participant 5, line 1296-1300).

Other participants echoed this value assumption; “There’s such a push to get rid of that nurse because you can replace that with a machine and a monitor” (participant 9, line 1014-1016). Additionally, there was widespread “expectations that electronics can’t make a mistake... and people take it for granted that technology can’t be wrong” (participant 9, line 890-896). Participants noted “there’s always money for these incredibly expensive [technological] systems that don’t quite fit the bill” (participant 5, line 1296). Not quite “fitting the bill” was further illustrated by participant 9, who recalled being given more equipment instead of increased human resources “we’ll [leadership] throw in a new pump, a new bilirubin bed and that should help you [nurses] right along...you don’t need more nurses, you don’t need more bodies and hands, no, we’ll just give you this [new technology] instead” (line 1041-1042). However, when the mother of a newborn baby who had jaundice was utilizing the new bilirubin bed required help with breastfeeding, participant 9 questioned “Where is the nurse that’s going to teach the mom breastfeeding, latching on? Where is the nurse that’s got the knowledge and time? Oh, we don’t have one of those” (line 1048-1050).

Participants validated their feelings that technology was valued over nurses by noting that the institution recently announced significant job cuts to nursing “yet we’re the first people to

be expendable, disposable, we can cut 30 jobs, 40 jobs, 50 jobs, it's just nurses" (participant 9, line, 1305-1306). In addition to job cuts, participants associated a culture of service with cuts to resources and support in order to save money. Fiscal savings from resource cutting was problematic because "it may look good for this year's budget but in the end, it's going to affect everyone" (participant 6, line 521-523), making reference to the negative impact on health care providers and patients.

Participants described 'Lean' as a significant "business model" change that exemplified the tenants of a culture of service. Lean is a set of tools and practices inspired by the philosophy of customer service used by organizations to enhance efficiency and to streamline workflow processes. Participants described Lean initiatives as "more corporate...more administrative" (participant 14, line 404-406), "service oriented" (participant 9, line 1102) and a means for leadership to "push the corporate vision [onto frontline staff]" (participant 9, line 441).

Participants suspected Lean was implemented to boost the image of the leadership team, "it's great to show on paper that we're [implementing Lean processes] and it looks really good on the institution and it looks good on certain people who are implementing these things but it negatively impacts the nursing staff" (participant 13, line 369-370). Other participants speculated leadership initially supported Lean processes simply because they needed to make sure it worked, "In the beginning managers and senior managers were very helpful in trying to get those things done because they had to make it [Lean] look good to say that it's working" (participant 13, line 44-45). Participants described Lean as a top-down approach, where leadership was "pushing it [Lean] into the [hospital] units regardless of whether or not it works" (participant 11, line 10-13). Another participant noted it was "just more changes being added to the pile of changes, more people above to tell you what to do and how to work" (participant 14, line 410-411). Additionally, Lean initiatives were described as having a "letter and a number [grade/score]" (participant 9, line 1104) and "key performance indicators"(participant 9, line 1105) attached to them. Although the Lean philosophy was implemented hospital wide,

participants struggled to understand its purpose, benefit, and fit with health care, “I don’t understand why they’re doing this [Lean], they’re not even thinking of patients” (participant 3, line 853).

At the outset, nurses did not perceive Lean negatively. Initially, participants observed positive results from using the Lean technique: “We got efficient. It [Lean] was in and of itself a good thing” (participant 9, line 1545). Lean was initially effective at facilitating “small fixes on the unit that might take a quick phone call or 5 or 10 minutes here or there by somebody to just improve one little aspect of how the unit functions” (participant 10, line 661-662). Participant 10 felt that “Lean was good for that” (line 663). Lean even fostered feelings of belonging: “People feel like they belong, ‘I’m making a difference on my unit for my colleagues’” (participant 14, line 258). Individuals who actively participated in Lean-related work felt they were “taking care of your unit ...[and the unit felt] more like a team” (participant 14, line 256-257).

The transformation of Lean into a negative change was the way implementation changed over time, “in the beginning I was kind of excited about it [Lean], a few people could see the positives it could bring. Now I feel people are very disenchanted with it” (participant 14, line 247-248). Lean goals established by leadership became unobtainable because adequate resources to support Lean work were not provided. This meant “we [nurses] don’t have the time to fix the problems for Lean to actually work” (participant 11, line. 951). Nurses perceived that the resources required to carry out Lean processes exceeded the projected fiscal commitments from the organization. Over time, this meant fewer resources were provided to support Lean initiatives. One participant illustrated this gradual evolution:

Over time anything that was a bit more complex, needed more resource, needed more things, needed help from management to free up nurses to do to those things, were not done (Participant 13, line 50-52).

The tipping point at which Lean fostered only a culture of service occurred when the goals became all about “the bottom line” (participant 4, line 472): “Lean has now been turned

into something that's very money driven and revenue driven, it's not a good thing anymore" (participant 9, line 1556-1557). Concurrently, the expectations of nurses regarding efficiency was limitless:

It [Lean] became a burden because now it's not good enough that we improved so much, now they [leadership] want you to do more, but we can't do more, we've already improved dramatically (participant 9, line 1546-1548).

A culture of service was associated with notions of nurses having to "do more with less" (participant 9, line 512):

The pressure on everybody right now is to get that bottom line and reduce that cost, reduce, reduce, reduce. But the patients aren't being reduced, the numbers aren't being reduced, the needs aren't being reduced. I just don't know what more they [leadership] expect, but they do, they expect more with less because we're going to get rid of a bunch of jobs and not replace them, and you'll [frontline nurses] just have to cope (participant 9, line 1705-1710).

Participants noted that "we're already stretched as far as we can possibly stretch without breaking" (participant 9, line 1709). They felt pushed "to be faster" (participant 2, line 19) in all aspects of their work, including patient assessments, the planning of care, implementing and evaluating interventions and documentation of care. These highly valued steps of the "nursing process" (participant 5, line 24), had seemingly "slipped away over the years" (participant 5, line 25) in light of the change initiatives that pushed nurses to be faster and do more with less. Having to "do more with less" and feeling pushed to "be faster" created what was perceived as a theme of "good enough", which evolved from two distinct service delivery values: good enough care and good enough nurses.

Participants felt the organization gave them resources and support to provide care that was only good enough. Good enough care was understood as care that met the basic biomedical needs of patients. Good enough care was provided with no regard for nurse

specialization, and was often associated with a “nurse is a nurse is a nurse mentality”. Good enough care was not holistic and did not include activities that supported a culture of care. Participant 6 argued that what good enough looked like in her work was an inappropriate number of nurses to meet patient care demands: “If it’s going to take 30 nurses to do the job then keep 30 nurses, don’t put on 27 and outrun them” (line 522-523), which she argued reflected current staffing practices.

Another example of a manifestation of good enough care was the recently implemented electronic documentation system that left one nurse feeling as though “I’ve left behind me a stream of what I believe is inadequate documentation” (participant 5, line 591). The documentation system was described as “binary” (participant 5, line 25); nurses felt they had to choose the closest option based on the tick box options provided, an “if not this, than that” (participant 5, line 24) form of decision that did not always accurately reflect their assessment findings. As participant 5 opined, “patients are not binary” (line 28). The documentation system “doesn’t capture our patients very well” (participant 11, line 731), nor did it allow nurses to “adequately capture what we’ve done for patients” (participant 5, line 79-80). In addition the system “shattered” (participant 5, line 103) patients into body systems and fragmented documentation records into multiple pop up screens, “there is no one place in the system where I can go and see [nursing assessment] and [subsequent intervention]...I have to go to multiple places for it” (participant 5, line 13-14). The electronic documentation system also appeared to shatter time because there was no way to “trend a patients progress over time” (participant 11, line 814). Participant 5 noted, “there’s no way to go back the day before and see ‘how was this patient yesterday, how was the patient the day before? Who did what to who?’” (line 102-103). This opposed ideals of holistic patient care. The electronic documentation system was a “one size fits all” (participant 5, line 613) system that did individualize of patients. A documentation system that did not facilitate holistic and individualized documentation was problematic for nurses because they were just “not happy with a good enough assessment” (participant 5, line

131) being reflected in the nurses' documentation. The "good enough" documentation of assessments left nurses on subsequent shifts "to kind of cobble together what we [nurses] know about this patient" (participant 5, line 1186). These kinds of scenarios did not foster truly "excellent" care delivery, as claimed in the hospital's mission.

Participants believed that the organization was satisfied with "good enough nurses". They supported these assertions by describing in detail the lack of adequate and appropriate training related to change initiatives. Freezing of nurses' continuing education due to budget cuts and an ongoing lack of support for nurses' well being during stressful work conditions accompanied rapid and continuous change. The most frequently cited organizational initiative that fostered the "good enough nurses" mindset was the growing use of a "floating nurses" strategy to address ongoing nursing staffing issues. This strategy promoted the belief that "a nurse is a nurse is a nurse", a concept all participants discussed. Floating strategy referred to the reallocation of a frontline nurse from his or her respective specific unit to another patient care area for all or part of a shift as a last-minute strategy to address a staffing shortage. Although floating was meant to be a positive measure to support intermittent and temporary nursing manpower issues, this floating strategy became a permanent daily solution to a sustained five-year staffing problem. Participants described how their specialties were no longer acknowledged or respected, "I've noticed that change, not recognizing the expertise that's there, the knowledge that's there in the nurses" (participant 14, line 449-450). This was contrasted with the way their specialties were once recognized "more than a decade ago you could still specialize and you didn't have to work everywhere" (participant 1, line 552). Now, the hospital's goal seemed to be to ensure units had enough nurses, but not necessarily enough adequately trained and specialized nurses:

My biggest issue is the nurse is a nurse is a nurse thing, if you want to quote me, that's my main issue. We need to be allowed to specialize and we need to be allowed to say,

“we don’t want to work in this area because it’s not our specialist area” (participant 1, line 1579-1882).

Participants explained that the management belief that nurses were interchangeable was because all nurses held the same professional title (RN) and therefore were assumed to be able to do the same work. The belief was “any nurse can work anywhere and do any nursing function” (participant 9, line 1460). Several participants felt as though nurses were used to simply fill holes in staffing, regardless of skillset or specialty. They described the lack of recognition of specialized nursing skills as “unfair and it needs to change, that’s one change they [leadership] needs to get their heads around” (participant 1, line 556-557). Participants took pride in their specialties, highlighting the time, dedication and financial commitment such specialization required, “all of your courses [and certifications] you have to have [to maintain employment], they’re quite expensive and they’re [leadership] not paying us anymore to go because there’s no money” (participant 9, line 771-773). These nurse participants wished the organization would recognize their expertise and the time and effort required to maintain specialized knowledge and skillsets.

Participants described several other change initiatives to staffing practices that emerged from a culture of service. Staffing the nursing workforce for the hospital moved from a decentralized unit-based approach to staffing decisions to a centralized staffing office manned by corporate staff that managed the hospital’s nursing workforce. In the former staffing model, the unit’s charge nurse would ensure nurses with the proper skill set were scheduled to care for the diverse needs of the unit’s patient population. In the latter model, personnel without nursing backgrounds and sometimes even without experience in health care now staffed the units seemingly with little or no input or influence from the charge nurse. This change in staffing practices supported the “good enough nurse” mindset: “When staffing took over they were put under pressure to make sure spots were filled, so there was some attitude of a body is a body is a body, a nurse is a nurse is a nurse” (participant 8, line 356-358).

Other new staffing structures that fostered this mindset included the rising employment of unit-based casual nurses and the increased use of the resource team nurses (e.g., a pool of corporate-based nurses specifically hired and trained to temporarily work where there were unmet staffing needs throughout the hospital). This was accompanied by a steady decline in the number of permanent full time positions. When full time positions became available, participants noted that management used the opportunity to create multiple part time positions as a way to reduce costs associated with staffing surplus and employment benefits: “A lot of nurses now are being hired into 0.2 [20% full time equivalent] and 0.3 [30% full time equivalent] positions rather than your full-time nurse who’s been there for 10-20 years” (participant 7, lines 12-15).

Another example of increasing service orientation was the influx of standardized practices. Participants’ linked standardization to the hospital wide adoption of Lean. Illustrations of standardized practices included intravenous administration set ups, medication administration times, and medication kit set-ups for specific high-risk groups of patients. For example, the kits contained a standardized number of supplies, alongside vials of specific medications that were most frequently needed for emergency situations with high-risk groups. Kits replaced the previous practice of preparing patient-specific doses of some or all of the required medications and having them ready at the patient’s bedside in the event of an emergency. Participant 13 noted how this change impacted her practice, “if in fact the patient had a reaction you would now have to fumble through all of these bags to get what you needed” (participant 13, line 357-358). This scenario contrasted her previous practice, “Whereas before you would have Benadryl drawn up. You were just giving Benadryl, it stopped the reaction right away” (line 358-359). Participants suggested that those responsible for the development and implementation of standardized practices did not understand bedside workflow and how, specifically, the processes altered nurses’ workflow. Participants also articulated that standardized practices were “not taking into account the individuality of that patient” (participant 13, line 634). The use of standardized practices was undermining nurses’ critical thinking skills:

The whole phenomena right now of standard work takes away critical thinking...it's almost like they [leadership] want us to be little robots and follow this sheet of, "this is how you do it and this is how everyone is going to do it", not taking into account that everybody does things a little bit different. We have policies and procedures in place, as long as you follow the policy and procedure, everybody has a way of nursing, but standard work takes that all away (participant 13, line 339-347).

Participants believed that these practices were implemented solely as a cost saving measure placing the importance of fiscal savings above patient safety, "[standard work] is compromising patient care, patient safety, for [a cost savings of] 20 cents for a Benadryl dose" (participant 13, line 367). Standardized practices were perceived to diminish the resources available to support patient care:

There's so much time and effort spent on these standard works...It's insane to me that time and resources are spent on those things rather than on patient care or patient education, which is so important for our patients (participant 13, line 375-377)

The growing compartmentalization of certain aspects of nursing care was another example of standardization. Participants 1 and 13 spoke of having an "IV [intravenous] team", which consisted of RNs designated to insert and manage intravenous access for all units of the hospitals. Other members of the nursing staff (excluding critical care) were not trained in intravenous insertion, and were therefore not able to perform this activity should the need arise, resulting in "delays in patient care" (participant 4, line 444). Multiple participants asked for this training, suggesting at least a core group of nurses per unit should be trained in order to improve patient care during hours the intravenous team does not work (overnight and weekends). The cost of training nurses outside of the specialized intravenous team was cited as the main reason for their requests being denied, "that's too costly so they're [management] not going to do it [train nurses]" (participant 1, line 336). Participants also noted that the compartmentalization of care activities altered their communities of practice, "before we used to

help each other out...now it has to be one nurse [to do task X] and the other nurse do all [task Y]...we don't work as much together anymore" (participant 2, line 34-47).

### **Culture of Care**

A culture of care was most often associated with "patient advocacy" (participant 11, line 76), "doing what's best for the patient" (participant 13, line 631), "contact with patients...supporting patients" (participant 9, line 404-406) and "good" (participant 9, line 1115), "safe" (participant 1, line 737) and "quality" (participant 5, line 1072) patient care. A culture of care supported "exceptional nursing care" (participant 8, line 174). Exceptional nursing care was depicted as care provided by specialized nurses, where "patients get a nurse that is really up to date in his/her field" (participant 1, line 1583), which translates to a "better standard of care" (participant 1, 1584). A culture of care fosters an environment where nurses "feel supported...feel respected" (participant 4, line 554) and "feel good about the care you're able to provide" (participant 4, line 555). Cultures of care have enough resources to support nurses leading to "low stress levels and high morale" (participant 4, line 556). In these environments nurses are "not just a body coming in and taking vitals and listening to your chest" (participant 8, line 171), they are "trained in their specialty area" (participant 9, line 1202), have "expertise" (participant 9, line 1202) and "the best skills and judgment" (participant 9, line 1203) to care for specific patient populations.

A culture of care is created by "contact with patients" (participant 9, line 404), which requires adequate time "at the bedside" (participant 2, line 628) "to build emotional connections" (participant 14, line 147) and to "build trust with patients and families" (participant 14, line 148). A culture of care fosters and maintains therapeutic relationships between patients, families and nurses. An example of this for participants was as basic as the terminology used within the organization when addressing and discussing individuals receiving care:

This nonsense about “clients”, they’re “patients”. Every one of them is a patient, every person who comes through that door is a patient and they have a whole family attached to them and they need care too (participant 9, 1158-1160).

Participants understood nursing as “both an art and a science” (participant 5, line 110), delineating that the relational work of nurses was caring activities that defined the art of nursing. Artful nursing practices included gaining important “science” assessment data through non-conventional assessment activities, including “providing a bed bath” (participant 14, line 719) and “cuddling babies” (participant 5, line 172). These creative means of assessment provided nurses with important patient data regarding skin integrity and mobility which helped inform nurses’ recommendations to the hospitals wound care nurse or physiotherapists. This “valuable part of our nursing work” (participant 14, line 142) also gave nurses opportunities to “evaluate [patient and family] their interactions” (participant 14, line 143). This meant nurses could “pick up more on certain things about your patient and interactions with their family, you evaluate their interactions” (participant 14, line 143-144). In some instances, these artful assessment strategies enabled nurses to advocate for the safety of patients, “we’ve picked up on CAS [Children’s Aid Society] cases during that kind of nursing work” (line 145).

Tending to the psychosocial needs of patients was also an important element of care, such as with the use of therapeutic play, “making water guns out of syringes with your patients and playing pranks” (participant 14, line 711). Interventions such as this were important to nurses because they “bring their [patients] pain and anxiety levels down” (participant 14, line 721).

A culture of care required that health care providers “humanized patients”, where “care is all about context, service is all about success” (participant 9, line 1132). Participants suggested caring could be evidenced in nursing practice by taking the time to “ask, ‘is everything ok? How are you doing, how are you feeling? Do you have any questions?’ That’s care” (participant 9, line 1094). Taking the time to “sit down with somebody and ask them to tell their story”

(participant 5, line 395) was also evidence of caring. These important therapeutic interventions were now perceived as “luxury” (participant 5, line 271) in a service-oriented setting.

Patient “hands on teaching” (participant 9, line 1054) was also considered an important component of care. It was in these teaching moments that patients and families often revealed important information about the care they required. However, participants 2 and 9 noted that there had been less and less time to provide patient and family teaching, while the distribution of patient teaching pamphlets was increasingly used as surrogate caregivers: “So, here’s a bunch of pamphlets from the breastfeeding league...call them up [if you have questions] and that’s how we send them [patients and families] home” (participant 9, line 1056-1058). Participants perceived the use of pamphlets in lieu of nurses as a cost saving measure associated with a culture of service. Participants 2 and 9 suggested pamphlets were not what patients and families needed from nurses, “all these pamphlets...that’s not what they [patients and families] need, they don’t need for us to give them paper to read, they need for us to sit in front of them and teach them, [to ask] ‘do you have any questions, is there something you’re concerned about?’” (participant 2, line 152-154). Participant 9 echoed the same sentiment, “We have handouts and pamphlets up the ying yang, we can hand out all kinds of pamphlets, but nothing beats that one to one human teaching, that one to one care” (line 1062-1064).

A culture of care individualized patients, and reflected “family centered care” (participant 2, line 539; participant 5, line 367; participant 10, line 81) and “holistic” (participant 2, line 117; participant 5, line 388; participant 10, line 106) styles of nursing which, for one participant, was a fundamental “philosophy of nursing care” (participant 2, line 977). It was through these family centered and holistic care activities that participants felt enabled to provide “good” (participant 9, line 1115), “safe” (participant 1, line 737) and “quality” (participant 5, line 1072) patient care. A culture of care was perceived as valuing the needs of patients more than money:

I mean no matter what the cost is we are talking about the safety of the patient. I don’t care if it’s costing you [leadership] an extra 100 dollars, that 100 dollars might end up

saving a life. Spend that 100 dollars. It comes down to the patient in front of you, it doesn't come down to how much the budget can afford (participant 2, line 870-877).

Participants recognized that a culture of care costs the hospital more money since many of the identified care activities required more time and resources than service-oriented activities: "We need to have time, we need to be given the time to care for our patients and I don't think anybody in this hospital wants to give us that time, feels they can afford to give us that time" (participant 9, line 1126-1136). Other participants echoed this sentiment. Participant 13 believed that management was "so budget focused and they just don't want to give those resources" (line 228-229) that were described as supporting a culture of care. Participant 6 noted that, "even if whatever is proposed [by nurses] is better for the families, but is not better for the budget, it's not happening" (participant 6, line 315-316).

A culture of care acknowledges that "healthcare is a fluid environment" (participant 13, line 30), where nurses require "flexibility" (participant 5, line 863) and "wiggle room" (participant 5, line 865) in their care provision activities because all patients with the same diagnosis do not always follow the same disease trajectory, some even displaying "rapid changes in acuity" (participant 13, line 11). Fluidity made it hard for nurses to "predict all that's going to happen" (participant 11, line 1122) on a shift, and thus to predict in advance what kinds of staffing and resource supports would be needed to care for their assigned patients. The expectation that nurses would and could provide this type of long-term planning for leadership decision-making was associated with a culture of service.

The importance of a care driven culture extended to nurses' collegial relationships fostering meaningful connections with colleagues that built a strong community of practice. In turn, a strong community of practice provided a sense of belonging, job satisfaction and fulfillment in nurses' work, but did require "extra steps to support people and have fun [at work]" (participant 6, line 345-346). Caring activities that fostered these collegial relationships included storytelling, both by inexperienced and experienced nurses, and informal mentorship. Nurses

telling stories to nurses was described metaphorically as “that little heart of nursing” (participant 9, line 616). These caring activities were important to participants because they were a means of socializing inexperienced nurses into the profession. As one experienced participant stated, “these stories are making the fabric of their [inexperienced nurses] work” (participant 9, line 611). Storytelling also facilitated learning:

It’s so important. There have been so many things I have learned in my early years at the hospital...they [experienced nurses] would tell a story, and I would remember that. That’s how you learn, that’s how you grow (participant 8, line 204-290).

In addition to storytelling, having time to socialize at work also fostered a strong community of practice. Examples included watching “something stupid on YouTube and we’d all be giggling and people would have music on,” (participant 9, line 817-818), “bringing in food” (participant 9, line 819) or having unit “pot lucks” (participant 6, line 349). Participant 6 fondly recalled the important socialization that occurred during her units “Virgin Margarita Sundays” (participant 6, line 347). These activities are important because, “having those moments to relax with your colleagues for that bit of downtime, having a laugh and a giggle, that’s important, that’s what keeps us all sane” (participant 11, line 1012-1014). Those moments “tie you together” (participant 9, line 713). Participant 9 speculated that there is a “need to feel that connection” (line 715) in the profession of nursing because of the nature of the work. Many nurses do not talk about work at home, rather they talk to other nurses because of a shared understanding, “you don’t tell your work at home, nobody [nurses] talks about their work to their friends or their family nobody gets this shit [nursing work]” (participant 9, line 604-605). These social moments “help morale so much, it helps people feel like more of a unit and get to know each other” (participant 6, line 353). The “social connections” (participant 9, line 720) that build strong communities of practice transformed “work colleagues” (participant 9, line 721) into “friends” (participant 9, line 721). Being friends with colleagues was important for participants because “you reach a point where you need to feel this person is your friend, you need a friend

that you can go to and you can discuss your shitty personal life with or your disaster at work” (participant 9, line 722-725).

Informal mentorship was described as an important activity amongst colleagues that facilitated both socialization into a community of practice and learning, “I had the most wonderful mentors and people to support me when I first started nursing...I learned so much from those nurses” (participant 8, line 295-297). Participant 5 noted that “mentoring and role modeling is so important to nursing” (participant 5, line 88) because the learning process is largely “monkey see, monkey do” (participant 5, line 89), meaning that inexperienced nurses often learn by watching more experienced nurses. Experienced nurses also explained their ongoing need for informal mentorship; “I still have questions that I want to ask people senior to me, to get support from others” (participant 13, line 852-853), “even as a more senior nurse...you need support, everybody needs support” (participant 4, line 550-522).

Gradual and purposive augmentation of workload in recognition of a nurse’s transition from inexperienced to experienced practitioner was another important way to foster learning and growth in the profession within a culture of care. For example, participant 10 recalled being assigned a “slightly smaller assignment than a nurse who’d be there for 20 years” (line 143) during her first year of practice. Participant 8 (lines 329-333) recalled a time when all nurses on her unit were required to work for a full year before caring for a specific, more acutely ill and vulnerable patient population. This augmentation enabled inexperienced nurses to “learn properly” (participant 10, line 144) and safely because they “weren’t swamped” (participant 10, line 144) or overwhelmed. Participants noted this support no longer existed, citing financial restraints as augmentation practices often require more nurses per shift.

A culture of care was associated with having “support from management to be able to look after yourself properly” (participant 13, line 257). Although access to the hospitals “wellbeing programs” (participant 13, line 262) was cited as an important safeguard in the maintenance of nurses’ wellbeing, participants cited numerous examples in their work

environment where leadership was “not supporting the wellbeing of frontline staff” (participant 13, line 261). Staff were “constantly missing breaks” (participant 12, line 315); “you don’t pee...Many shifts I’ve come home and haven’t peed for more than 12hrs” (participant 13, line 248); and “you’re not eating” (participant 7 line 278). Participants recognized that “if you’re to take all the breaks that you’re entitled to you don’t leave on time” (participant 14 line 87). Participants noted they and their colleagues were working “crazy amounts of overtime” (participant 2, line 978), and that they were “not getting to claim their vacation time” (participant 9, line 677). Additionally, some nurses were being given “stupid shifts from staffing” (participant 9, line 675) that did not allow enough time in between shifts to rest and adequately prepare for the upcoming shift. In addition, the wellness programs offered were tailored for office staff as leadership “put them at times where only office people can go...they’ve overlooked what can benefit frontline staff doing shiftwork...those are the people they need to look at” (participant 13, line 263-265).

The growing culture of service became irreconcilable for participants for two reasons. First, when nurses were providing service, they felt they were unable to provide even a “good enough” level of care, let alone good or excellent care. Thus care and service were perceived as mutually exclusive “we are so busy providing appropriate service that the care part of it is very hard to incorporate” (participant 9, line 1092-1093). Service provision took precedence over care provision “we provide the best possible service that we can but it isn’t the best possible care” (participant 9, line 1099). Second, a culture of service challenged participants’ deeply engrained values and beliefs about the nature and purpose of health care. Participants understood service as “you get your chest x-ray...prescription for your pneumonia and you get told how to take it and you get told these might be the side effects and you get sent away” (participant 9, line 1068-1070). Care in this situation was understood as the nurse noting that the child’s mother is crying, and taking the time to ask, “Why are you crying?” (participant 9, line 1072). It was in this caring act that participant 9 better understood the socioeconomic

complexities of this family's life and the impact of this child's illness within a more holistic context:

"I don't even have bus fare to take him [patient] home...I left my husband and I'm staying in a shelter and I don't even have food for him and I don't know what I'm going to do and I just lost my job and I can't finish my school". That's care, not service (line 1073-1079).

Participant 4 discussed the difficulty experienced when asked to embrace change initiatives that challenged her values and beliefs. Doing so made her feel as if she were being untrue to herself:

It's difficult when you have to buy into a philosophy of something before you really believe in it. You don't really have a choice, you're being told to implement something that you don't believe in and you're supposed to be the cheerleader for it too, so it's a dichotomy. You have your own values and beliefs about it, you don't believe in it but you've got to implement that (participant 4 line 358-364).

Similarly, participant 9 highlighted the financial pressures placed on her by the institution driven by a culture of service that conflicted with her ideals of care:

None of us [nurses] want to say it's all about the cash, because it isn't for us. So it's really hard. On the one hand to be pushed from above saying, "how quickly can that patient leave? Can you kick them out? Can we give them a bus ticket?"...They're [leadership] expecting that money to come in, they're going to have to get patients out and fill up those beds in a timely fashion. It's a vicious cycle; it's not really what we want to do. We don't want to push (participant 9, line 1186-1195).

Other participants articulated that the values of a culture of service did not reflect their values regarding the purpose and role of nursing, "I'm not there to worry about the bottom line, I'm there to nurse" (participant 1, line 307). Participants saw patients differently than leadership, "we didn't ever look at a patient and say you're going to cost X amount of dollars...now there's this bottom line dollar sign attached to it [care]" (participant 9, line 410-423). Feeling pressure

that their care should be driven predominantly by budget considerations was difficult for nurses, because “that’s not how we [nurses] work” (participant 9, lines 424).

It is important to note that participants argued that nurses were not adverse to all organizational change. They noted, “change is just part of our job” (participant 5, line 587) and “our profession is one of the quickest changing professions you’ll ever come across” (participant 8, line 683-691). One participant stated, for example, “I really don’t care what pump you [leadership] pick, as long as it doesn’t affect the care I have to give my patient, as long as it doesn’t take away from the care I give” (participant 2, line 619-622). Some types of changes were deemed unnecessary, “it’s not that I don’t like change, it’s that there’s a lot of change that happens at [the hospital] that to me, serves no purpose and just makes things more difficult on frontline staff” (participant 10, line 245-247). Nurses often had “huge reservations” (participant 5, line 589) about changes grounded in service, because they were perceived by participants to negatively impact care. Because the participants’ understandings about the purpose for change was different from that of the HCO’s leadership — “There’s this big gap between their [leadership] understanding of what change means and our understanding” (participant 1, line 1316) — they were adverse to change initiatives that were “seeking change because it helps with their budgets” (participant 1, line 1359) or were “not really going to impact us in terms of health care and what we deliver” (participant 1, line 1345).

In contrast, participants were accepting of change that fostered a culture of care, noting that, “change can be good in certain circumstances” (participant 10, line 246). For participant 1, “the way they [leadership] go about changing things is more of the issue rather than the change itself per se. It’s more about the way it’s done” (participant 1, line 244-246). For example, participant 10 stated that they were “not against the smart pumps” (participant 10, line 450), but recognized that “there’s ones on the market that do work significantly better than what we ended up getting” (participant 10, line 451). When describing what this nurse meant by “better”, the participant referred to pumps that required less alterations to nurses’ workflow, less steps to

program, and had demonstrated less patient safety issues, all elements of pump technology that would better support a culture of care. Change initiatives that fostered a culture of care were described as those that were “essential to health care and the improvement of that care” (participant 1, line 1345). Participant 5 reiterated the kind of change initiatives that nurses endorsed:

Every change needs to be moving us forward, moving us closer to achieving that excellence of care. That is our [nursings] mission (participant 5, line 1292-1293).

Participants recognized the importance of a balanced budget but they argued that budgetary decisions needed to minimize negative impacts on patients and staff:

I can appreciate balancing a budget, I try to appreciate both sides, sometimes you have to make decisions based on budget that aren't that popular but you can also go about it in a way that minimizes the impact or negative impact it will have and I think that's where the hospital falls short (participant 10, line 688-691).

### **Navigating Change**

How many more mistakes do they [leadership] have to make before they understand that nursing has something to offer in terms of how to move healthcare forward in a constructive manner? (Participant 5, line 254-265)

Participants described change as evolving throughout multiple phases that included assessment, planning, implementation and evaluation. Many discussions about the process involved in organizational changes were embedded in their understanding of the purpose of change and continued to highlight the tensions between a culture of service and a culture of care.

### **Assessment and Planning**

The assessment of, and planning for, much of the change initiative lay in the hands of leadership, highlighting the disconnect between who was making the decisions (leadership) and who was living with the daily realities of those changes (nurses). From the participants'

perspective, organizational change always directly impacted nursing care, yet individuals who did not seem to understand the day-to-day realities of nurses made the decisions. Participants attributed this to the fact that those in leadership positions making decisions were either not nurses [e.g., “a lot of the people that are making the decisions within the organizations are people that have never nursed” (participant 5, line 549-550).], or if they were nurses, they were now so far removed from the bedside that they “don’t know the reality of how things go” (participant 6, line 233) and they “forget that it [change] is really difficult for staff” (participant 1, line 596).

Participants described how multiple change initiative decisions, including the purchase of the electronic documentation system and intravenous pumps and medication cabinets, were made based on only “brief consultation” (participant 5, line 62) with frontline nurses, which was deemed inadequate or ineffective, or did not include any frontline nurse consultation: “we didn’t get any of that [consultation]. It was like, ‘well here’s the new pumps’” (participant 14, line 205 - 207). Participant 5 recalled, “there was no consultation with the people who were going to be using it [electronic documentation system] the most” (line 621). Another participant reiterated these concerns regarding the purchasing of multiple technologies in general:

My own personal experiences have been that a lot of the time they [leadership] don’t involve the frontline workers from the get go, they’ve already purchased something, they bought something and it’s too late [for consultation] (participant 4, line 202-205).

Participants noted that, “things [regarding change] were done behind closed doors” (participant 8, line 599). Decision-making was a process that often had “no transparency” (participant 8, line 599). If information was given, it was “very vague” (participant 7, line 211), presumably because nurses would foreseeably raise concerns that management did not want to address.

When consultation occurred, participants deemed it inadequate based on the small nursing representation. For example, committees regarding change initiatives had only “a small

number of nurses” (participant 1, line 1226) on them. Participants identified three reasons for the inadequate representation. First, “it was really hard to get changes in your schedule done so that you could attend those meetings...They [staffing office and clinical managers] wouldn’t [allow changes]” (participant 1, line 412). Second, the consultation strategies lacked sensitivity and appreciation for the complexities of nurses’ workdays and the multiple demands on nurses’ time. Often meetings and consultations were scheduled at times nurses could not attend, “they’re at one and two in the afternoon. Well sorry, but I can’t do those things at one and two in the afternoon” (participant 11, line 748-751). Third, low representation resulted in nurses being outnumbered by other health care professionals, such as physicians, who were perceived as having more power in decision making, “no matter how much work and effort you put in...there’s always a last word...no matter if it [change] is good for nurses or not” (participant 2, line 57).

Information regarding forthcoming change initiatives was sometimes conveyed through what was termed “lunch and learns”, however these were deemed problematic by participants because “we don’t even always get our lunch breaks so that’s not really a great way to relay information to us” (participant 7, line 178-181). Extra nursing staff to relieve nurses to attend was not provided.

Equipment trials proved problematic for participants, most notably because the equipment was not easily accessible or trials were non-existent. For example, participant 14 recalled that leadership “didn’t bring multiple pumps on the floor and get all the nurses during their shift to try all the different ones” (line 206-207). Another nurse recalled how different medication cabinets were set up in a non-clinical area of the hospital for nurses to examine but noted, “I was working nights the entire time they were on so I missed all of that opportunity. Of course they always format it just for day staff, basically for the nine to fivers who are not even nursing staff” (participant 11, line 529-530). Even when trial equipment was brought to the unit, it appeared there were not enough to facilitate adequate usage by nurses, “unless it was in your [patient’s] room...you’re running your butt off all day, you’re not going to take the time to go into

the medication room and clean off a thermometer just to try it. It was an effort to track one down” (participant 7, line 348-349). Not having protected time while on shift to properly trial equipment was also “stressful” (participant 7, line 402) for participants. Participant 7 stated that it was common to be asked to stop while in the middle of a nursing care activity to look at a prospective new piece of equipment and provide immediate feedback: “‘Let me show you this new bed pan wrap’ and you’re like ‘I don’t care!’ I have no time for this, I’ll figure it out on my own, and that’s what it comes down to” (participant 7, line 402-406). This participant remarked that she valued the opportunity to provide feedback but that the structure in which the opportunity was provided interfered with her ability to provide patient care, which was her foremost priority.

Participants declared that the “honest feedback” (participant 4, line 223) nurses provided during times that consultation or trials were made available was often not utilized in decision-making. Participant suggested leadership “didn’t listen to anything” (participant 3, line 873), leaving nurses feeling “angry”, “not valued”, and “not respected” (participant 4, line 220). One participant noted this had become the trend “over the years” (participant 10, line 329), suggesting that leadership was “just going through the motions of letting you feel like you have a voice in the discussion but they have no intention from the start of ever taking anything you say to heart” (participant 10, line 329-347). One participant wished leadership would “take our opinions seriously...they want to initiative change so they ask us our opinion but they don’t take it” (participant 12, line 441-442). The issues described by participants during the assessment and planning phases of organizational change were relevant to the implementation and evaluation phases.

### **Implementation and Evaluation**

Participants discussed at length the implementation phase of multiple change initiatives. Participants described implementation as occurring too quickly, “changes were too fast, and a lot of people felt that way. I think it was rushed” (participant 14, line 297-298). Another

participant stated that changes were “inflicted in a very aggressive manner” (participant 5, line 619), suggesting that when leadership decided to undertake new change initiatives nurses were expected to initiate those changes promptly and without question. Participants noted that the training for new equipment often felt “rushed” (participant 3, line 237). They needed and wanted to have “more hands on” (participant 2, line 661) time learning how to use the new equipment because at the end of training, nurses “didn’t feel comfortable” such as that which occurred “with the pump [new intravenous pump]” (participant 2, line 662). When participant 2 requested a pump to be left on the unit for nurses to practice on prior to implementation, she recalled being told by leadership “No, they’re too expensive” (line 660). Some participants found that training was done too far in advance of implementation, “you forget” (participant 4, line 173). The “classroom environment” (participant 4, line 168) used for training did not reflect the complexities of working with new technology at the patient bedside alongside multiple other technologies. Participants also noted that the timing of training made it challenging to attend training sessions.

Participant’s ideas regarding what they wanted in terms of training demonstrated multiple needs amongst the nursing group; an array of learning styles and personal needs. Some participants, for example, did not want to come in on their days off (participant 7, line 384). This statement was declared in the context of mandatory attendance at a “half-hour training session” (participant 7, line 385) and “not being paid” (participant 7, line 386). One participant suggested that paying nurses to come in on their day would be best, but noted it would need to be at least a half day to make it worth their while, suggesting this scheduling option would ensure “more people would be coming out and doing the training” (participant 7, line 400). While some participants believed that “scheduled time outside of shifts is key” (participant 7, line 416) for learning how to use new technology, they, readily acknowledged that for others who had co-existing commitments (e.g., multiple jobs, childcare responsibilities) “it’s hard for them on their days off” (participant 1, line 429). Participants also remarked that this

alternative training strategy conflicted with how leadership envisioned training because it would cost additional money, as evidenced by participant 1's experience: "They wouldn't allow you to come in [for training] on your day off because they'd have to pay you extra" (line 233-234).

All participants who discussed training agreed that it should not occur while they were on shift providing patient care. It was noted that when coverage for training was provided, it occurred haphazardly. Handing over patient assignments to replacement nurses for an hour or two during a shift ultimately distracted nurses from the training session because they were preoccupied with the welfare of their patients in their absence. Participant 7 explained why, in her opinion, short periods of training during nurses' shifts were inefficient and unsafe:

During my busy shift someone is like, "Here I'll cover you for an hour and you go do your training"...It's not that simple to just go and leave everything and come back...It's not efficient for training because it completely depends on how your patients are doing. And I think the whole reason we work 12-hour shifts is because we can see how our patients are doing over the course of a day. And for someone to come in [to cover me] just for an hour, I mean they don't know what that patient's baseline is...My hang-up with letting someone just take over for an hour is that I just don't feel it's safe (participant 7, lines 413-427).

The nurses' temporary removal from the patient care unit for brief periods throughout a shift impacted their ability to learn and retain material. Their thoughts were focused elsewhere. As Participant 1 acknowledged, "when you're doing it [training] on a work day it's so rushed...you have to worry about working the rest of the day once it's finished" (participant 1, line 237-240).

Some participants felt that the training provided did not adequately prepare them to troubleshoot the technology in the patient care setting because "real" clinical situations were not addressed in training. For example, during the training session for the new intravenous smart pumps, Participant 11 recalled asking the trainers "What do I do if I need to override the [smart

pump] limits?” (line 601). She remembered being told, “oh, you won’t need to” (line 602). Participant 11 repeated her question because she felt the trainer was “clearly not hearing me” (participant 11, line 605) and noted that the trainer had failed to address the questions concerning ““what if this happens, what if that happens?”” (participant 11, line 632-624). Not knowing how to troubleshoot was problematic for nurses because they feared it would compromise their ability to provide safe nursing care, which reflected the tenants of a culture of care and specifically being a knowledgeable and skilled worker.

Participants suggested avoiding hospital-wide change initiative rollouts as a way to alleviate the multiple issues described during initial implementation, some of which had the potential to comprise patient safety (e.g., not knowing how to override the intravenous smart pump in an emergency situation). Participant 5 noted it was not uncommon that “they [leadership] launched [multiple changes] hospital wide in a day” (line 1163). Participants suggested taking an approach that would facilitate “a unit to unit implementation rather than an entire hospital wide one” (participant 11, line 864-865). This type of approach would enable the hospital to mediate the “many kinks [that needed] to be worked out” (participant 6, line 144) before rolling out to the rest of the hospital. Participants believed that this strategy would decrease the potential magnitude of patient safety concerns. The aforementioned concerns stemmed from how multiple changes interrupted care, and were not perceived to be in the best interests of patients.

During the implementation phase of multiple change initiatives, participants applauded the use of expert users (e.g., a small group of nursing staff trained to support a specific change implementation), noting, “the actual philosophy...I support...it’s a great concept” (participant 4, line 174-175). How the expert user was actualized in practice was problematic, “when that’s actually put into practice it sometimes doesn’t work” (participant 4, line 176). Participants who had experience being an expert user noted that the training happened long before the implementation phase, “so much time passes” (participant 4, line 170) and that the training

provided was not long or robust enough, “there wasn’t enough time in the classroom” (participant 4, line 177). These factors created situations where “it’s really hard to be the support person for staff when you don’t even feel like the expert” (participant 4, line 173-174).

During the implementation of multiple changes, participants noted that expert users continued to have patient assignments, albeit at times with a reduced patient load. This impacted the expert users’ abilities to offer support to their colleagues, “they’re [expert users] also nurses on the unit so they could also have their own patients that they’re dealing with and they’re not able to come and help” (participant 6, line 154-155). Some participants noted expert users were regularly given full patient assignments to address ongoing staffing shortages in the hospital: “We were short staffed so they [expert user] got pulled...to do patient care” (participant 13, line 644 - 645). This action was perceived as a withdrawal of leaderships’ commitment to provide expert users in “supernumerary” (participant 13, line 644) positions so that nurses would be supported during the implementation phase of a change initiative. Instead, the expert user nurse was expected to manage both a full patient assignment and support staff with change initiative implementation. Expert users were “spread so thin” (participant 11, line 31), that it created situations where participants had “brand new pumps, we had no support” (participant 13, line 647-648) and “it was just your close colleagues trying to troubleshoot everything...just pushing buttons until we get it working” (Participant 6, line 154-159). Similar examples were provided when the electronic charting system was launched. Expert users from a particular unit were not supernumerary and were given full patient assignments to address staffing shortages. Many nurses on the unit “felt so overwhelmed” (participant 4, line 305) attempting to document on complex patients. Participant 4 recalled the aftermath of these experiences soon after implementation: “All they [nurses] heard from the electronic charting implementation team was ‘you didn’t do this right, you didn’t do that right’, so no one felt very supported at all” (participant 4, line 306-307).

Many additional changes (e.g., software updates, updates to policies and best practices, changes to equipment, and changes to nursing workflow) were communicated to nursing staff via email. This form of communication made it difficult for nurses to implement changes because they viewed email communication as a linear form of communication that did not allow for the opportunity to clarify, ask questions or raise concerns. Email communication embodied a passive form of learning:

It [email] doesn't give us opportunity to ask and answer questions, why do we get so caught up on emails?...something you interpreted may not be what the intent was...[email] doesn't give you an opportunity to ask questions, doesn't give you an opportunity for hands on, like [new machines]. I can't figure it out from just a picture; I need to go actually play with the thing (participant 3, line 1021-1029).

Email was as a platform that was not conducive to reciprocal exchanges and did not foster collaborative problem solving. Participants said they preferred active, hands-on learning with feedback loops that facilitated the consolidation of learning. Participants suspected that email communication had been widely utilized in light of budget cuts that froze education funds for nurses, "the funding isn't there for our education" (participant 8, line 741). Participants saw the increase in email communication as a way for the institution to provide nursing practice education in a way that was less costly than formal education sessions.

Participants did not mention formal feedback mechanisms following implementation. They suggested this was a shortcoming of change implementation in their workplace, "they [leadership] need to ask [nurses] what's working well, what's not working well, what are your unique needs" (participant 4, line 212-213). Nurses provided informal feedback following implementation; for example, explaining to management how certain elements of changes negatively impacted their ability to care for patients. One particular example concerned the electronic documentation system. Both expected and unexpected downtimes occurred with the system. During these downtimes, nurses lost access to the patients' clinical information,

including nursing documentation and directives for care planning. As participant 5 declared “it’s gone into vapor” (participant 5, line 1183). During downtimes nurses were left “combing through [the paper-based] doctors’ orders, combing through medication sheets” (participant 5, line 1186-1187) to compile a patient record, “because we have no nursing record of it” (participant 5, line 1188). If downtimes were lengthy, nurses were required to revert to paper-based charting, which sometimes had to be transferred later into the electronic record.

Some participants shared that concerns raised with nursing leadership after implementation of the electronic documentation system were met with indifference, “we expressed concern to two different management people who told us, ‘well this is what’s happening you’re just going to have to live with it’” (participant 10, line 571-573). Participant 5 raised concerns with a senior administrator following what she described as an “irate nightshift” (line 1089) during which she felt the electronic documentation system hindered her ability to document her nursing care. She worried that the kind of charting the system facilitated was “inadequate documentation” (line 591). Leadership’s dismissal compounded her frustrations:

I remember her [senior administrator] patting me on the shoulder and saying, “Well when we get a system you approve of, we’ll have won”, and I thought, oh she just thinks I’m bitching but you know they were legitimate complaints (participant 5, line 1090-1093).

### **Leadership and Communication styles**

Participants highlighted that management’s communication and leadership styles significantly impacted all phases of organizational change. It was clear that nurse managers played a pivotal role in shaping frontline nurses’ experiences of organizational change. Participants described two very different kinds of change management leadership and communication styles that impacted their experiences: autocratic and democratic.

**autocratic.** Leaders that used the autocratic style of management communicated in a manner that was aggressive, dictatorial and “very confrontational” (participant 13, line 684). As Participant 13 stated, it was a “my way or the highway” (participant 13, line 683) approach to

rapid and continuous change. This style of communication was an indicator of autocratic leadership and fostered a “change in morale...animosity...and at that time we had a lot of staff turnover because of that” (participant 13, line 682-685). It also alienated nurses with regards to ready acceptance of change initiatives and fostered a culture of silence.

The autocratic leadership style involved “micro-management” (participant 13, line 308) and participants perceived it as “a lack of support from management staff” (participant 7, line 247). This created an environment where “it’s easy to go unheard because there aren’t a lot of places where you can go or people you can go and talk to, and feel open talking about it [work challenges]” (participant 7, line 251-253). The unease and uncertainty to speak created a “culture of not wanting to say anything” (participant 7, line 254). Participants noted that under this style of leadership they were “asked to do things” (participant 7, line 263) that were perceived to be cost saving measures but that also had the potential to compromise patient safety. For example, requests from management included adding another patient to a nursing assignment, ““can you not just squeeze [another] patient”” (participant 13, line 300) or caring for a patient that had complex care needs that exceeded nurses’ expertise. Participants reflected that “it doesn’t really seem right” (participant 7, line 264) but they did not want to say anything because they did not “want to ruffle feathers and I don’t want my manager to not like me, I don’t want to get fired” (participant 7, line 265-266). Participants hesitated to speak up because “you want your job so don’t want to rock the boat yet and go against management” (participant 11, line 60). Participants who experienced autocratic leadership began to feel that bringing their concerns forward about a change initiative was a pointless endeavor, “what’s the point of even bothering to [voice concerns] because we’re not going to get anywhere” (participant 13, line 133-134)? This was exemplified when participant 10 described a situation where an inexperienced nurse asked for more mentorship shifts with an experienced nurse, noting that the inexperienced nurse completed her mentorship shifts during a period of rapid and continuous change in the HCO. The inexperienced nurse “did not feel prepared” (participant 10,

line 150) to take on a full patient assignment independently, but she was “denied by management because they [nursing unit manager] didn’t want to pay for it” (participant 10, line 151-152). This style of leadership reflected the values upheld by a culture of service.

This autocratic style appeared to result in a growing amount of nurse blaming within the organization. One example of the expression of blame frequently cited was the handling of nurses’ requests for overtime, which increased during periods of rapid and continuous change because of heavier workloads that accompanied managing and adapting to change initiatives. One participant recalled that upon requesting overtime she had to “sit down with the charge nurse and explain what you could have done differently... and have a meeting with your manager” (participant 7, line 273-275). These actions were perceived as acts of “bullying”; that is, this participant felt “bullied into not taking overtime” (participant 7, line 276). Other participants recalled similar situations: “you wind up working overtime and they won’t pay you for the overtime...because you haven’t followed the ridiculous process” (participant 14, line 54-53), which involved alerting multiple individuals in leadership that you foresaw your workload would become unmanageable. Participants suggested that overtime was denied because of the increased costs incurred to the hospital, “Oh, god don’t you dare go in for overtime, no, no, don’t go in for overtime, because we’re broke” (participant 5, line 326-327).

Another example where participants felt nurses were blamed was associated with an ongoing problem with the newly implemented intravenous pumps. Numerous nurses repeatedly reported large volumes of “air in line alarms” (participant 10, line 447; participant 13, line 566; participant 12, line 259). All levels of leadership, senior administrators and nursing unit managers “told the nurses we just didn’t know how to prime [intravenous] lines properly” (participant 10, line 459). Priming intravenous lines was noted to be a fundamental nursing skill that participants did not believe they or their colleagues had any problems carrying out. Management then had a representative from the intravenous pump company “retrain nurses how to properly prime IV [intravenous] tubing” (participant 12, line 267). Problems with the

pumps did not go away following the re-teaching. It took over a year before the organization's leadership accepted that this was a pump product issue that could not be solved by the company and these pumps were eventually replaced with another product line.

Similarly, ongoing malfunctions with the medication-scanning device were another example of a change initiative where participants perceived that nurses were blamed. Participant 10 recalled how many nursing colleagues would "bring up the issue...it was an everyday issue for every nurse, it was not just one nurse who might be doing it wrong. It's everybody, all the time" (line 612). Yet, management repeatedly told nurses "you guys must be scanning wrong or doing something wrong" (line 616). This blaming went on for "months...before finally they changed our scanner" (line 620).

Participants also reported that working with new technologies was excessively time consuming, yet, they recalled being told by management, "it doesn't take longer" (participant 10, line 206) and that they should "organize your assignment better" (participant 1, line 400). As an illustration, participants referred to the introduction of the new electronic documentation system. They stated that nurses raised concerns on numerous occasions about the increased time needed to provide and obtain handover report at the change of shift in light of the way patient information had been structured in the electronic record and because the shift report structure itself had been necessarily altered. Yet, nurses were placed in situations where "leadership argues that you're just not organized enough" (participant 1, line 1067).

Participants described the lack of acknowledgement and support during periods of change as a key-contributing factor to the creation of a culture of silence, noting that they were often told, "you're going to have to find a way to make it work because it's [change] happening" (participant 10, line 575-576). Participants felt their concerns about change implementation were "doubted" (participant 12, line 257), were "basically just brushed off" (participant 10, line 204), which was "frustrating, not having the leadership... to advocate [for us]" (participant 11, line 243-244). One participant recalled being told to "get with the program" (participant 10, line 206) and

that management accused nurses of “just complaining and making a fuss over nothing” (participant 10, line 206). This style of leadership was associated with making claims that nurses “just don’t like change” (participant 10, line 208) and were “complaining” (participant 10, line 209) for the sake of complaining.

Nurses perceived autocratic leadership as a dictatorial, top-down decision making style that further promoted a culture of service. Language used to express these decisions and structural style of communication reflected this leadership style: “Nothing was done collaboratively...you’re just told, ‘This is what’s happening, go with it’” (participant 6, line 92-95); “They [leadership] came out and told us ‘that’s how it is’” (participant 6, line 599). One participant deemed this style of communication a “dictatorship” (participant 8, line 599), noting this style of decision-making was not effective because “we’re [nurses] the ones that are going to have to make it [organizational change] work” (participant 8, line 599-600). Communicating decisions about change initiatives was often accompanied by a lack of transparency with participants recalling, “they [leadership] weren’t really giving us any information. They weren’t saying how we would be impacted; they just said this [change] would change the way in which we provide patient care in the future. Well what does that mean?” (participant 4, line 345-347). Information about change initiatives typically came in the form of email communication but participants perceived email communication as another behavior that demonstrated an authoritarian style of decision-making: “No, we [nurses] weren’t involved in that [change], they just basically did it and sent us an email” (participant 3, line 585-586).

**democratic.** In contrast, some leaders demonstrated a democratic leadership style. This egalitarian, collaborative and “laissez-faire” (participant 13, line 680) style fostered a culture of care and was a blessing during rapid and continuous change. Democratic managers were most often “actually nurses...[who] had the expertise to really understand...because they’ve been in the situation...knew what it was like” (participant 11, line 1072-1008). These managers had “gone through the trenches...they’ve walked in our shoes so there’s an understanding there”

(participant 13, line 731-733). Prior experience as a frontline nurse was “really, really crucial” (participant 11, line 1083) because it seemingly made these managers, “reasonable” (participant 13, line 724) and able to “have empathy for nurses” (participant 13, line 734), characteristics that were not associated with the autocratic leadership style. Participants stated they were more comfortable approaching clinical managers who had a democratic leadership style with problems or concerns about change initiatives, and were more likely to respect their managers’ responses: “I’m more willing to listen to her [manager] because I know she is more willing to listen to me” (participant 13, line 744). Some participants noted that with this leadership style they could “talk to [management] about anything” (participant 7, line 393), “[management] listened, [management] tried to work things out and help...takes nurses opinions, respects nurses” (participant 13, line 727). Participants identified these supportive managers as individuals who encouraged participation, partnership, and autonomy, along with having an “open door” (participant 6, line 393) policy that enabled nurses to air their frustrations regarding change initiatives.

Participants recognized that even though managers seldom fostered positive change for nurses, it was important that they consistently demonstrated support for their frontline staff as they dealt with the difficulties of rapid and continuous organizational change. Often this support came in the form of authentic conversations and empathetic actions. In fact, one participant noted that a democratic leadership style - one that “shows a more caring management style for employees” (participant 13, line 755) - created “less barriers to change” (754). Participant 11 offered insight into why the autocratic style of management exists in healthcare and also why it is frustrating for frontline nurses:

I see it... with the other managers that are so far removed from patient care they don’t have a clue what’s going on...they need to not be so far removed from the bedside that they lose perspective on what really goes on in a day...I think it takes a certain kind of person to do it [management]. And probably the people that can deal with it are the

people who are not linked to the bedside because they can just separate themselves so far that it [living within a culture of service] doesn't bug them, but you need to find that balance somewhere (line 364-371).

Despite reporting eroding relationships with the institutions leadership team, participants still spoke of most nurse managers in empathetic ways, even when they were frustrated with management decision-making. Participants noted that nurses "don't understand management stuff either...I'm a frontline nurse...I don't get what it means to fill out a budget and have to meet that budget" (participant 1, line 1326-1331). Participants empathized with the difficult position managers were in, but also recognized their own frustrations with many decisions made within their workplace. Although participants understood management's position, "I do see it from both perspectives" participant 3, line 1123), they added that not all change initiatives implemented made sense from a frontline nurse perspective: "I see where management is coming from but then I can also say, 'well come on now, these changes you're making aren't making sense'" (participant 3, line 1124-1127). Similarly, participant 1 expressed her empathy for management by stating that "I don't want to be a manager, you can't please everybody all the time" (participant 1, line 1377), but also described her frustrations with the lack of reciprocated empathy:

It's [management] one of the hardest jobs in the world to do, but then so is our job, and I don't think they feel that way about what we do. I don't think they realize that our job is hard because we're implementing everything that you [management] want us to and more (participant 1, line 1378-1381).

Many of the precarious situations frontline nurses experienced were exemplified in participants' accounts of the challenges faced by nurse managers. For example, participants expressed that clinical managers also experienced a culture of silence and were reluctant to speak out about rapid and continuous organizational change for fear of being on what participant 7 called "the chopping block" (line 223). Nurses illustrated how the same silencing

mechanisms impacted nurse managers who had to comply with directives from senior leadership, or they too could be on a “chopping block”. This was one of the ways in which participants reconciled the lack of support from nurse managers throughout change initiatives. Regardless of the empathy participants expressed towards their clinical managers, participants conveyed ongoing frustrations with the leadership team as many of leaderships’ actions throughout the various phases of change negatively impacted nurses.

Participants wanted leadership to communicate in a manner that was open: “Be open with them [nurses] on decisions that are made, and why they’re made” (participant 10, line 400). It was important that leadership not “hide aspects of decisions that they make” (participant 10, line 401), but rather “be upfront about it [change]” (participant 4, line 473). Participants sought “transparency throughout the [change] process” (participant 10, line 403) and for leadership to “be honest” (participant 10, line 405): “That’s all anyone wants, is honesty” (participant 4, line 475).

## Chapter 6 Findings: The Distress of Rapid and Continuous Change

I can see that people aren't happy at their job. They feel like they're just getting through right now, they're not enjoying it. It's not as fun as it used to be (participant 9, line 691-692).

Changes that were "fostering service" (participant 9, line 1066) as opposed to "fostering care" (participant 9, line 1066) were "really harming staff, it's harming their morale, their sense of self-worth and their ability to care" (participant 9, line 1559-1560). Nurses "went through months of low motivation" (participant 8, line 594) and experienced "a solid 2 years of negatively when they went through those changes [electronic documentation, intravenous pumps and medication pumps]" (participant 14, line 40). Participants recalled that prior to the beginning of rapid and continuous change implementation, "8, 10, 12 years ago, people were just generally happy all the time on the floor" (participant 10, line 410), however now, "nobody is happy anymore" (participant 12, line 30), "it's [work] not a happy place to be" (participant 8, line 594), "it's [work] very stressful, you can just feel it. People don't seem as happy" (participant 14, line 45-46). This made the environment "less of a joyous place to work" (participant 10, line 418), where "the atmosphere...over the last 5 or so years...has gotten more negative as workloads have increased and people are treated so poorly" (participant 10, line 298-301). Collegial conversations now "constantly focused on discussing decisions that were made by management...or different negative things that have happened" (participant 10, line 411-412). This was hard because, as participant 10 stated, "I think I can say all the people that I work with love the nursing profession, they love the work they do with patients and families" (line 285-286). Participants communicated that "I [still] love nursing, but I don't walk around with a smile on my face like I used to" (participant 8, line 217). Participants found this difficult because the families of patients who had multiple stints in the hospital over the years saw the drop in moral amongst nursing staff, "she [mother] commented on how different the morale is now compared

to a number of years ago, she said she can feel that as a parent” (participant 6, line 275-277), reiterating participant 8’s assertion that “if we are happy with our work and enjoy our work, it shows when we’re giving care” (line 213).

As noted previously, participants witnessed “a big departure of nurses” (participant 9, line 283) in light of multiple change initiatives. Ongoing job dissatisfaction continued to affect those remaining nurses, who felt that “a lot of us thought, if it [work environment] stays like this, I’m going to quit” (participant 14, line 47). Nurses in this workplace “began to question ‘maybe this isn’t the right place for me, maybe I should quit’” (participant 9, line 525), questioning if “maybe I need to quit nursing, maybe I need to leave the hospital” (participant 11, line 341-342). “The temptation” (participant 9, line 621) to leave “was very strong” (participant 9, line 621) for some nurses who felt they “do not have to put myself through this stress, I do not have to continue this” (participant 9, line 626). Some participants increasingly felt that they “don’t want to do this [nursing]” (participant 11, line 341), and that “I don’t think I can nurse anymore” (participant 2, line 983).

Participants identified that rapid and continuous change initiatives varied in significance based on the magnitude of impact that an initiative had on frontline nurses. This included, but was not limited to, such losses as the time available for delivery of direct care to patients and families and the availability of nursing resources. Impacts of change were described as alterations in work flow processes, policies and procedures, cognitive thinking patterns, and intra and interprofessional communication patterns. These alternatives lead to the loss of patient caring activities, intensified patient safety concerns, fractured communities of practice and dismantled nurses’ identity. Results were negative emotional repercussions that reflected anger, distrust and distress. Participants’ experiences reflected elements of change fatigue that included apathy, burnout, and feelings of voicelessness and powerlessness.

### **Loss of Time**

During periods of rapid and continuous change nurses described a loss of time to carry

out important aspects nursing work, such as building and sustaining relationships with patients, families and colleagues, which all reflect a culture of care. Participant's time was redirected to managing disruptions that accompanied changes, most notably the required reorganization of nursing workflow and the manipulation of new technologies which created a net loss of time at the bedside. Participants attributed the loss of time to the overworking and understaffing of nurses that accompanied the push for efficiency and instigated rapid and continuous change in the participants' workplace. Participants noted that workloads were not augmented during change implementation, nor during the following days and weeks. Augmentation of workload was important because nurses believed it would allow them to successfully adapt to changes. Participants noted that in lieu of augmented workloads "There was just an expectation [from leadership] that you were going to be able to fit it all in [patient load plus managing changes] and you were going to be able to adapt [to all the change initiatives]" (participant 1, line 1242).

In addition to workload and staffing concerns, a number of key factors redirected nurses' time away from highly valued patient caring activities within a culture of care, to activities that were associated with a culture of service. Participants identified general factors including changes to patient populations and the work environment that required reorganizing of nursing workflow. More specific factors included: change initiatives such as Lean philosophy, the reconfiguring of unit spaces, technological change initiatives including intravenous pumps, medication cabinets, electronic documentation system, and leaderships communication strategies.

The first factor was that participants noted they were "busier" (participant 12, line 224), in light of increasing patient acuity, "we have sicker patients" (participant 12, line 224), "We no longer have a recuperative patient, nobody is getting better at a hospital. The level of acuity is through the roof" (participant 5, line 460-461). Despite the fact that "the acuity level is a lot higher...there's no reflection of that in our workloads, and in the changes that are occurring, there's no reflection of that" (participant 13, line 824-826). Participants felt that "the institution is

putting more pressure, more things on us” (participant 12, line 225), but not increasing staffing or resources because “they [leadership] are so budget focused and they just don’t want to give those resources because that means they’ll have to call in another nurse or they have to pay us overtime and they don’t want to” (participant 13, line 228-231). These factors increased nurse’s workloads, meaning nurses had less time to provide patient care, “but I feel that I’m not able to give that time to family and the patient now and that’s part of the treatment” (participant 13, line 232).

Nurse’s roles and responsibilities had changed over time. Frontline nurses were increasingly “expected to not only be a bedside nurse, but to know what the organization is up to, their action plans, and this and that” (participant 1, line 1358-1359). However, time commitments required to engage in organizational activities that were extraneous to patient care activities, were unrealistic in light of the many other ways in which nurses were juggling their time, “It’s just so busy and you can’t sit down for 5 minutes, let alone go to some sort of meeting that’s really irrelevant to you, to your everyday working life” (participant 1, line 384-385).

The role of the charge nurse had changed as well. Charge nurses were frontline nurses who took a leadership role in organizing and supporting nurses on a specific care delivery unit for the duration of a shift. Charge nurses were responsible for creating patient assignments for frontline nurses, ensuring nurses had the resources to meet the needs of patients, as well as liaison with the nurse educator and nursing unit manager. Charge nurses were once responsible for “mentoring new nurses...that was part of the charge nurse’s job” (participant 8, line 27). They were also once responsible to help inexperienced nurses “organize their day...help with time management” (participant 8, line 282). One participant recalled how the charge nurse used to “eye ball every room and talk with the parents and see what was on the agenda for the day” (participant 8, line 278-279). The charge nurse would offer to help with nursing tasks like “prime new IV [intravenous] tubing” (participant 8, line 277) if the nurses on the unit were too busy. These activities made charge nurses feel connected to the other nurses, patients and families

on the unit. Charge nurses “don’t have time for that now” (participant 8, line 279) because their responsibilities now included, “doing statistic sheets, sitting down with the manager for half an hour, going to bed flow meetings” (participant 8, line 280-282). Now the role of the charge nurse was what participants called “more corporate” (participant 9, line 451). This change meant that experienced nurses were tasked with many of the previously held responsibilities of the charge nurse for instance, experienced nurses took on, “helping us younger nurses with things we’re just doing for the first time” (participant 7, line 38) while maintaining their own patient assignments, “they’re expected to [fulfill those responsibilities] on top of that [patient assignments]” (participant 7, line 37). The loss of time experienced in relation to these general changes were intensified by the implementation of multiple changes:

That’s the reality with budget cuts and shortages just in general, now we have even less time that we did before. And then you pile on the pumps, pile on the computes that you’re fighting with (participant 11, line 953-956).

The second factor identified was the way nurses had to reorganize their workflow to adapt to specific changes, all of which required additional time. Reorganization of workflow was most notably in response to multiple new technologies that required manipulation by nurses, “we spend so much time wrestling technology, and it has brought us away from those intimate moments at the bedside” (participant 5, line 390-391). It was in those “intimate” moments at the bedside when caring activities occurred, for example, taking the time to assess and address needs beyond biophysical, asking a mother: “Mom, if you’re going to stay, here’s a bed chair for you, we’ll get you a pillow too. Who do you need to call? Here’s the phone, here’s how it works...Do you need diapers? Do you need formula?” (participant 9, line 1161). These activities included noticing that “baby sounds hungry” (participant 9, line 1162) or that patients and families were not comfortable. Providing comfort in a context of care “is more than morphine, it’s a warm blanket, a pillow” (participant 9, line 1164). When participant’s time was redirected to many other pursuits, these care activities slipped away, “I didn’t bring diapers, I didn’t bring

formula, we didn't offer, we didn't have time to offer...these are things that are part of care that we do less and less of because we're in more of a hurry" (participant 9, line 1163-1167).

Another participant described the loss of similar care activities, "a kid's in pain and you give them pain meds but then you have to walk away and just leave them by themselves because you don't have the time to sit with them and care for them, it's not right" (participant 7, line 304-306). Medication delivery was considered a service, but non-pharmacological pain management strategies were a care activity. Participants regretfully recalled families having to ask for things that brought them comfort, "Can I get a blanket?...Can you make my child comfortable?" (participant 9, line 1164), "can I have a hot pack?" (participant 7, line 301). Participants argued, "that's not something you [parents and patients] should have to ask for" (participant 9, line 1163).

Time constraints were further compounded by the concurrent and continuous nature of change initiatives. Participants highlighted that change after change caused exponential losses of time that did not appear to dissipate. Losses were combined with additional change initiatives that too required more of nurse time:

We've added 45 minutes extra [per shift] for electronic charting and 15 minutes for pumps and all these other things they keep instituting that add up over time. There's serious time concerns for nurses (participant 10, line 353-355).

The third factor that redirected nurses' time away from patient care was the implementation of Lean philosophy. The implementation included a daily unit meeting that occurred at a set time every day, on every unit, lasting 15 minutes. Management expected all nurses to attend the daily meeting, "it was an expectation, and if you were not there it was not a good thing" (participant 13, line 468). The meeting was a venue for the multidisciplinary team to discuss both unit-based and hospital-based concerns, and to devise collaborative problem solving strategies. Examples of issues discussed at daily unit meetings included, but were not limited to, concerns with where/how nursing supplies were stored, communication strategies

amongst disciplines, “pharmacy always calling first thing in the morning while we’re [nursing] trying to get handover,” (participant 8 line 539-540), and unit based concerns unrelated to patient care, “ongoing issue with bags and shoes in the back room” (participant 11, line 965). Resolutions often focused on decreasing inefficiencies at the unit level. However, the resolution process involved those present at the meeting taking ownership for the resolution, “Lean was added work, if nurses suggest things, we have to make the change, it’s now added work for us” (participant 14, line 290-292). Other participants reiterated these concerns, “no one has the time to be able to fix them [issues raised at daily unit meeting]” (participant 11, line 962), “I don’t have that time or resources, I’m busy enough taking care of patients and trying to do the best that you can to look after your patients, you don’t have time to do extra” (participant 13, line 124-126). Work associated with the daily unit meeting was perceived as “extra” work, above and beyond, and not directly correlated to, patient care activities. To engage in Lean activities, nurses felt they must sacrifice care activities:

If you have identified yourself as a leader for that ticket then you have to find your own time to then do that so either you take away from patient care and do those things or you do it in your own time (participant 13, line 120-121).

The fourth factor that created a loss of time was the reconfiguring of unit spaces nurses frequently required access to. An example was the need to reorganize clean utility rooms where nursing supplies are kept. Reorganization of a multitude of supply room contents resulted in situations where “it takes longer to do our jobs” (participant 12, line 188) because “it takes longer to find things, you used to just grab it [supply] and go, and now we stand there for five minutes looking for a product that we know is there, but you don’t know where it is” (participant 12, line 188-196). Another participant noted the impact of this change, “in doing so [reorganizing] people spend far more of their day just trying to find stuff” (participant 10, line 255).

Changes to the clean utility rooms was a standardization effort management purported

was implemented to better support float nurses, “they [leadership] wanted to standardize all the clean utility rooms on all the floors so that they’re similar for people that float” (participant 10, line 272-273). Participant 13 was given the same rationale from leadership, “having things in the same place would help workflow for float staff” (line 91-92). Yet, nurses who worked on these specific units saw this rationale for the change imitative as “not really a valid reason” (participant 10, line 274). Every unit appeared to stock patient population specific supplies, so no two units had the exact same supplies, “each floor has specific supply needs...we have specific supplies like dressing change supplies that maybe only our floor needs...another floor has supplies that we don’t need” (participant 10, line 276-280). Participants perceived the initiative as needless, suggesting that if the hospital better staffed inpatient units, they would not need to intensify the use of float nurses. Another time-leaching change was the implementation of a locked door between clean utility rooms and medication rooms, “our med room used to lead into our clean utility room, they’ve closed it off” (participant 10, line 635-636). This change increased the amount of time required to obtain frequently required supplies, “IV [intravenous] tubing for [medications] are in the clean supply room, but we need them in the medication room”, which now meant nurses had to “walk all the way around the unit” (participant 12, line 221-222) to get some medication supplies. Another change was that hospital linen was locked in the clean supply room, so nurses’ now had to “walk all the way around the unit to get a towel, and then come all the way back and if they [patient or family] want something else you have to go all the way around and go back, so it’s time [that’s lost]” (participant 12, line 226-228). Infrastructure changes took time away from nurses, which could, as noted by participant 7, “add 10 minutes to my day, it doesn’t sound like a lot but 10 minutes is precious time to a nurse” (line 355-357), “all of these things just add more and more time that you just end up taking away form patient care” (participant 10, line 636-638).

The fifth factor was multiple technological changes including the intravenous pumps, medication cabinets, and electronic documentation system. New intravenous pumps required

much of nurses' time. Participants noted "it takes far longer to program it, every time you need to program a new IV [intravenous] solution, program a medication" (participant 10, line 349-50). There were multiple steps involved in the programming, which required entering a patient's weight multiple times for one medication, one participant described the "cascade of checks to do that [administer medication], I once counted and I think there's 12 clicks to put on a [medication]" (participant 5, line 663). The multiple steps required were "disruptive to workflow" (participant 3, line 664) because they interrupted other aspects of nurses work, for instance, attempts to complete electronic documentation, "I've now got up 3 or 4 times, interrupted that 10 minutes I want to get some kind of computer charting done" (participant 5, line 665-666). Since switching to the new intravenous pumps participants noted a sharp increase in the amount of pump alarms that nurses had to manage, "so many problems for us with pump alarms" (participant 10, line 447), "they rang all night long, like 20, 30, 40 times a night" (participant 10, line 454), which resulted in nurses having to spend "hours and days trying to problem solve" (participant 10, line 458). The intravenous pumps required large amounts of troubleshooting, but "troubleshooting takes away time from the patients" (participant 6, line 370). Participants felt that they were now "spending more of our time babysitting technology than I am with my patients" (participant 5, line 171-172):

The new pumps...they're not as good as the old ones...I have to send these ones off more often to replace them because they will error code and keep ringing off occluded...and you're like "but there is no occlusion! I checked the line 5 times now, there is no occlusion!" (participant 7, line 359-361).

Pump errors subsequently resulted in time spent filling out repair forms and navigating "that process" (participant 7, line 365) to receive a new pump. Pumps were no longer available on the units for nurses to collect as the need arose, nurses were now required to page a porter using an online system and wait for the porter to receive the request. Porters then went to the central "pump room" (participant 3, line 662), located elsewhere in the hospital, and nurses

waited for the porter to return to the unit with a different pump, “you have to call for a new pump, that was a new change too, having the pumps in one place and now having porters, having to put a call in to get the pump brought to you... that slows you down” (participant 14, line 129).

Medication cabinets caused multiple nursing delays. There were long line-ups during times of the days where many patients received medications (morning and evening), “you’re in a line of five people waiting to get your medications” (participant 14, line 306), “you spend 10 to 15 minutes just waiting in line,” (participant 10, line 564). Participants noted that if they left the line to do other patient care activities they incurred more delays, “if you don’t stay in line it could be another half hour before you get your medications” (participant 10, line 557). During these busy times, participant 10 felt they were “always 2 people away from getting your meds” (line 558). These long lines seemed to occur “during the busiest time of the shift when you’re trying to do all of your [initial patient] assessments” (participant 10, line 560). Wait times were exacerbated when the “med cabinet has blocked or the medication won’t come down because it’s stuck and you have to wait for somebody to come up [to fix it]” (participant 13, line 602-603). This malfunction meant that “then it’s stuck for everybody, it’s not just stuck for you, it’s stuck for the 3 people behind you in, shutting down the whole medication cabinet” (participant 13, line 604-605), rendering all other patient medications inaccessible. In addition, the biometric login technology created delays “you have to wait for someone to log in and out to get the medications” (participant 13, line 612).

Nurses had concerns that “the medication wasn’t always there” (participant 4, line 445), which resulted in them “looking everywhere for the medication and that takes time, and then you fall behind on your care” (participant 2, line 486-487). When medications were not in the medication cabinet nurses were to “phone down to pharmacy, which takes up more of your time” (participant 13, line 593), or “we had to fill out the [missing medication] sheets and fax to pharmacy and wait for another dose of medication to be delivered to the unit” (participant 14, line 313). Prior to the medication cabinets “it [medication] was always there waiting” (participant

4, line 446), “the meds used to be on the counter [in the medication room], you would know if they were there straight away...you would just go and get them and that would be the end of it” (participant 13, line 609-611), however the implementation of the medication cabinets meant that “now everything is locked” (participant 13, line 613).

Malfunctions with the medication-scanning device also took time from nurses. Some medications “wouldn’t scan properly” (participant 14, line 312), “the scanner doesn’t work half the time” (participant 10, line 595), “I’ll try 4, 5, 6 times to scan and it doesn’t work” (participant 10, line 597). Participants lamented that nurses “were spending so much time just trying to get it to scan...you’re constantly trying to scan and nothing scans” (participant 10, line 609-611). Participant 11 stated her and her colleagues were frequently “wasting time trying to get it to scan” (line 524). Instead of “standing there scanning the thing 50 times” (participant 3, line 1044) noting, “that was ridiculous” (participant 3, line 1044), some nurses were “just visually verifying meds, I wouldn’t scan it” (participant 3, line 1045). Manual verification by the individual nurse as an alternative to scanning medications was not acceptable practice, “when we manually verify [as opposed to the scanner], we get told we’re not allowed to manually verify” (participant 10, line 596). Nurses then spent even more time trying to scan medications to avoid repercussions for manually verifying medications, as it was stated that unverified medication reports linked with nurses unique biometric login were sent to their superiors for review and follow up.

The electronic documentation system consumed a significant amount of nurses’ time, “online charting is just ridiculous, the amount of time we have to be on the computer putting information in” (participant 13, line 497-498), “the computer charting is just awful” (participant 11, line 731). Participants spent large amounts of time “on the computer, you click here, click there, it takes forever” (participant 2, line 492-492). Participants observed that “we’re spending more time clicking” (participant 5, line 379), which meant other care activities were sacrificed, “that’s [charting] taking our time, instead of time to sit and listen [to patients and families]”

(participant 5, line 383).

The login processes “takes forever” (participant 13, line 503) because “you wait the 5 minutes for the computer to load and authorize our settings and double check your password” (participant 5, line 96-97). The process was so tedious because login was required “every single time” (participant 13, line 503) a nurse wished to document, which took “30-45 seconds for it [computer] to boot up each time, if you log in 15 times in a day you’re talking about 10 minutes of sitting at a computer, 10 minutes gone” (participant 10, line 190-193). Nurses time was also redirected to the maintenance of their user accounts, “we’re [nurses] updating our passwords, half the time this [password] doesn’t work and half the time that [password] doesn’t work” (participant 5, line 678-679).

They described the charting as an “inefficient system” (participant 5, line 26), consisting of multiple screens and interfaces that required simultaneous manipulation by users, “you’re flipping from sheet to sheet to sheet just to get information” (participant 11, line 812-813), “I have to sort through the electronic charting to get to a specific category and that process in and of itself can take 10 minutes” (participant 7, line 60-61). The multiple interfaces did not communicate, “they [multiple interfaces] can’t communicate and talk to each other” (participant 10, line 484), which failed to meet nurses expectations of a electronic documentation system: “you think one [interface] would flow over to the other and it doesn’t” (participant 11, line 811). In addition to not communicating internally, the system did not communicate externally with the multiple other documentation systems co-existing in the hospital, which resulted in nurses having to access [if available] multiple patient charts to collect pertinent information:

We’ve got 4 different charts for each patient and half of it is still in paper charting so you’ve got a paper chart, you’ve got an inpatient chart, the ER chart, the outpatient chart. If they go to the OR, you’ve got an OR chart. You can’t even access all the information from all the different areas at any given time because you can’t see them (participant 10, line 513-518).

The documentation system was not intuitive, as the workflow of the system did not reflect how nurses work and were used to documenting their care, “it’s [electronic documentation] not intuitive, it is still not intuitive [after multiple updates], things don’t flow the way they should” (participant 11, line 810). Participants struggled to find the correct places to document their care activities “you want to document something, you know it’s got to be in the system somewhere, but where to find it?” (participant 8, line 65-66). Retrieval of information was also challenging, “trying to go back and find something that is only available if you hover a cursor over a very small asterisk and the minute you move that cursor away it disappears into a puff of smoke” (participant 5, line 379-381).

An additional complication was the forced duplication or re-entry of charting associated with the electronic documentation system. Participants found they were double charting in multiple ways. Nurses would document their patient assessments on scrap pieces of paper in the patients room, so as to not forget pertinent information when inputting into the computer, “you’re double charting all the time because for everything your transcribing on your piece of paper, your work sheet, which you then have to put into the computer, there’s just no simple way of doing it” (participant 13, line 507-508). Participants identified multiple places in the documentation system where the same information could be entered “like blood glucose, some people would put them on the vitals sheets, well there’s actually a place for them in the assessment tool” (participant 8, line 68), which resulted in “a lot of double charting” (participant 7, line 49). Nurses would enter the same information in multiple places (double chart) out of fear of reprimand, “you don’t want to get slapped on the wrist you didn’t chart the way you’re supposed to chart” (participant 14, line 117), and fear of important patient information going unseen by other health professionals who must make patient care decisions, “people double and triple charting things because we were scared” (participant 8, line 70). One nurse noted that she would frequently “chart at one time and I go back and it’s not there. I have to re-chart it all, I find that I constantly re-chart all the time” (participant 12, line 99-100), which created an

additional need for data re-entry.

In addition to double charting and re-entering data, participants noted they were “spending so much time free-texting because you just can’t capture [the care you’ve delivered]” (participant 11, line 734) via the tick box options provided by the system, “it’s [electronic documentation] restraining us from actually recording what we see” (participant 5, line 136). Another reason nurses free texted in large volumes was that the documentation system appeared to sever the nursing process, where nurses felt unable to capture the “results of care” (participant 5, line 82), patient “re-assessment” (participant 5, line 82) following care, and follow up care planning, “how we are going to improve upon it [care]” (participant 5, line 82).

Subsequent updates to the electronic documentation system required nurses to document more, “the computer slowed us down a lot, they [leadership] wanted more accuracy, so kept adding to the documents” (participant 2, line 520-521), “now you have everything but the kitchen sink in this charting” (participant 2, line 508). Such updates meant that nurses were to document more, and more frequently, “yet they [leadership] wanted us to go faster...I mean, God, do you know how much clicking I have to do here” (participant 2, line 520-523).

In addition to time constraints related to the task of documenting, nurses lamented that “there’s a shortage of computers” (participant 11, line 839). There were not enough computers to meet the needs of all the staff expected to use the electronic documentation system, including nurses, physicians, allied health, and support staff (unit clerks), “good luck finding a computer” (participant 12, line 101). The institution attempted to provide alternatives, for example “we had the tablets but the tablets never even took off. I think there were only half a dozen staff that used them and they’ve taken them away because we were like ‘no, these are no good’” (participant 1, line 810-812). They were “no good” because they were difficult to use and frequently lost Internet connection, rendering them un-usable. Participants lamented, “again (emphasis) we didn’t get asked about those [tablets], we didn’t get asked, ‘do you like this model’” (participant 1, line 813-814).

The institution provided workstations on wheels, but similar issues arose, “they always freeze” (participant 2, line 83). The lack of available functioning computers was one of the reasons nurses would document their assessment findings on scrap pieces of paper and then document electronically when a computer became available, noting it took “time to find somewhere to chart, when you don’t have that time” (participant 7, line 71-74). Demands on nurses times were compounded by having to document on multiple patients, “If I have to spend 20 minutes charting, that collects over a period of time when you’ve got 4 times [4 patients] you’re going to be charting an assessment every X amount of hours” (participant 5, line 1149-1156). Documentation requirements increased with the implementation of the electronic documentation system, which required nurses to document more frequently “all of the demands that they’re putting on us, ‘make sure you chart IV [intravenous] assessments hourly’, so many hourly checks” (participant 14, line 105-106). Hourly charting proved challenging for nurses yet retroactive charting was discouraged, as participant 14 recalled being told, “don’t retro chart, you should be within the hour” (line 108). Nurses were to be logging in and documenting hourly, which, as previously noted, took a lot of time.

Nurses juxtaposed the change to electronic documentation system to the simplicity of the previous charting system, which was paper-based, “before we used to have clipboards beside the bed, you would do your assessment, document it on the clipboard, and that would be it...instead of writing on your little sheet of paper” (participant 13, line 499-500). Participants recalled “hearing a lot of nurses say, ‘I wish we could go back to the old way’ [of charting]” (participant 14, line 102-103). They yearned for the old way of charting because, “you would be able to stand there and chitchat [with patients and families]” (participant 13, line 498-502), “I remember when we used to chart...it was so much nicer, you were able to spend time with your patients, you were able to give proper care” (participant 2, line 489-491). Time spent with patients was a caring activity. Electronic documentation and patient care were now viewed as mutually exclusive activities because charting could no longer be done at the bedside alongside

caring activities, “there’s so much time now spent on the computer instead of at the patient’s bedside” (participant 5, line 31-32). Electronic charting was noted to be “one of the biggest things that’s taken time away from our families, from spending time with the families” (participant 13, line 504-505) because “It actually takes far longer to chart on a patient in a day with this electronic program than it did before when we were using paper” (participant 10, line 196-197).

The final factor contributing to the redirection of nurses’ time was the communication strategies leadership used to disseminate changes. The hospital relied heavily on email to communicate changes to nurses, “since I’ve been here everything is through email” (participant 7, line 197), “you’re getting a flood of emails...they’re making changes and they just fire off emails to you one after the other” (participant 1, line 460-667), which required nurses’ time because “you’re expected to read the email and understand it all” (participant 1, line 653). Nurses did not have time to check their email at work, “I don’t have time to check my emails when I’m at work” (participant 7, line 193) because they “have other things [patient care activities] to be doing” (participant 11, line 206) and time to check email was not allotted during nurses working hours. Nurses missed important change updates when they did not frequently check their email. Participant 12 returned from a week long vacation and asked her colleagues about a change she noted after being unable to find a nursing supply, “did anybody see that they changed these syringe tubings?” (line 475). Her colleagues told her that “it was on my email, well, you know what I haven’t even actually had time to look at my email to find out that you [leadership] changed a product” (line 479-480).

The time required to manage multiple changes negatively impacted nurses abilities to carry out important care-driven activities, including focusing on the delivery of family centered care:

It’s all time taken away from our poor patients that are just sitting there, and they [leadership] say it’s family centered care (participant 2, line 538-540).

### Loss of Resources

Participants experienced a pronounced loss of resources as a result of multiple change initiatives. Resources lost consisted of human resources; both experienced and non-experienced nurses, and non human resources including training opportunities. Participants believed that previously allocated resources had been redistributed to multiple costly change initiatives. Human resources were lost through attrition; some nurses were unable to work within a growing culture of service where they felt frequently challenged in “doing what’s best for the patient” (participant 13, line 631). The non-human resources participants lost were those associated with a culture of care, for example ongoing training and education opportunities that enabled nurses to provide “good” (participant 9, line 1115), “safe” (participant 1, line 737) and “quality” (participant 5, line 1072) patient care: core elements of a culture of care (described in the previous chapter).

In light of the impact of multiple organizational changes many nurses, both experienced and inexperienced, left the organization, “I’ve seen a high turnover of nurses, not just the unit I work on, but everywhere. It’s pretty prevalent” (participant 5, line 12-13). The sudden loss of human resources was alarming for participants because they believed “there aren’t many things that will make a nurse leave her job, not many things” (participant 5, line 1357-1358), yet some of the changes so drastically altered nurses work lives that they chose to leave the organization. Some experienced nurses took early retirement, “I’d be lying to you if there weren’t retirements that weren’t precipitated by that system” (participant 5, line 1349), “she [experienced nurse] said, ‘this is not for me. This electronic documentation, obviously I can’t do it’, it was one of her deciding factors to retire early” (participant 4, line 312). Another participant recalled, “in the last 5 years a lot of turnover of our senior staff who before [rapid and continuous changes] would not have thought about leaving the unit” (participant 13, line 329-330). Some experienced nurses “tried it [electronic documentation system] and thought, ‘you know this isn’t going to work for

me', so off they went" (participant 5, line 1355), "it [electronic documentation and medication cabinets] was too much for senior nurses to handle, so they left" (participant 7, line 33). Other experienced nurses went on to work at other institutions that did not have the same technologies, "people continued to work elsewhere where they didn't have an electronic documentation system" (participant 5, line 1351), which was described as "a loss for the whole team" (participant 5, line 1359). Attrition resulted in "the unit losing all that knowledge that is with those nurses" (participant 13, line 334), "years and years of knowledge you'll never learn in a textbook... that knowledge is gone from the unit and that's such a loss to nursing" (participant 13, line 831-835).

Experienced nurses who remained, and now filled the mentorship roles of nurses who had left, often felt that they too, still needed support from nurses more senior. They questioned their own abilities to mentor, "have I experienced enough to give that advice to someone else? I will give it my best ability but I still have questions that I want people senior to me...to be my buffer...but I don't have that anymore" (participant 13, line 855-858). This loss was followed by an influx of inexperienced nurses', "you're left with very junior staff" (participant 13, line 331) who required mentorship into the profession, and also support managing the newly implemented changes. This exacerbated the loss of time for experienced nurses' because they were tasked with juggling multiple and concurrent demands on their time, which included heavier patient assignments in light of the nursing inexperience on their respective units, "It's hard for those senior nurses because they are working with a lot of junior nurses and getting really, really, heavy assignment and that's really hard for them" (participant 7, line 35-36). Participants attributed some of the increased workload to the fact that inexperienced nurses often did not have the required training to care for specific patient populations that required specialized treatments, "there's not enough trained staff so you're the only one trained...so you're assigned to do it all [specialized treatments]" (participant 13, line 176-177). Experienced nurses were "pulled in all different ways" (participant 13, line 216) adapting to multiple changes,

balancing their own workloads and mentoring and supporting inexperienced nurses, “they’re providing expert knowledge to a new hire...but they’re still learning all the new equipment too” (participant 6, line 438-451). This created a work environment where “the older nurses are not there to help mentor the young ones” (participant 8, line 282).

The hospital lost experienced nurses and this was compounded by a marked increase in the loss of inexperienced nurses, “we had 6 nurses leave all at once, they were younger nurses who were working part time. They didn’t like the direction the department was going in and they all left” (participant 9, line 267-270). The loss of experienced nurses left inexperienced nurses to care for very high acuity patients without the support of proficient nurses to mentor them; these nurses were “treading, barely keeping their heads above water” (participant 8, line 288). High acuity combined with the intensification of nursing workloads associated with multiple change initiatives left these inexperienced nurses consistently “swamped” (participant 10, line 170) because “they’re given the workload of an experienced nurse from day one” (participant 10, line, 149). This fostered an environment where “there isn’t allowance for them to grow into an experienced nurse” (participant 10, line 147). It was not uncommon for “shifts where the most senior nurse has two or three years of experience” (participant 10, line 161-170). The data suggests inexperienced nurses also left because they could not secure full time employment: “they’ve done a couple of casual jobs in our unit over a period of 2 years, that’s their experience” (participant 5, line 116). Nor could they secure consistent employment on one unit, “they’ve floated around the hospital for 2 years because that’s all they could get, and they left [the hospital]” (participant 5, line 116-117). Participants suggested that inexperienced nurses who left the organization did not like the transient nature of their work:

We’re losing some really good, solid nurses...they’re taking charge, they’re showing great leadership qualities and mentoring. They’re becoming preceptors, and they’re leaving because they’re tired of just being shoved back and forth between units (participant 8, line 196-200).

This loss of human resources was exacerbated by the announcement of widespread layoffs of nursing staff, equating to “50 FTEs [full time equivalents], one FTE can be up to 5 nurses so it’s not just going to be 40-50 nurses it could potentially be more than that” (participant 7, line 220).

Participants described additional resource depletion including the lack of preparation and training available prior to change implementation. They assumed inadequate training was because “the funding isn’t there for our education” (participant 8, line 741). because it had been diverted to multiple change initiatives, including the purchasing of “hugely expensive equipment” (participant 5, line 520). The intravenous pumps were one example, “we spent millions of dollars on these new [smart technology] pumps” (participant 10, line 452). New equipment required “incredibly expensive [operating] systems” (participant 5, line 1298) required to run equipment, which resulted in “significant operating costs” (participant 5, line 35):

We’re millions of dollars in the hole and don’t tell me that those systems aren’t responsible for that (participant 5, line 555-556).

Nurses believed that the purchase of the Lean business system depleted excessive amounts of hospital money: “the amount of money that they’ve spent on Lean is atrocious...so much wasted money that’s gone into Lean” (participant 11, line 1036-1042). Nurses speculated that additional money had also been spent on changes that did not directly impact patient care, such as the reorganizing of clean utility rooms: “they [leadership] spent thousands of dollars on salary to redo the whole back room for no apparent reason” (participant 10, line 265). Participants articulated that organizational spending ventures were outside the realm of caring activities: “There’s so much time and effort spent on these changes, it’s insane to me that time and resources are spent on those things rather than on patient care” (participant 13, line 374-376).

The prefatory training participants spoke of was for managing new technologies or new patient populations, which accompanied multiple change initiatives [unit

amalgamations/alternative off-servicing of patients]. Two specific participants spoke of lack of training when caring for new patient populations. The first participant recalled that “for our [new patient population] we get 3 days of training, which is not enough” (participant 14, line 536). The second participant recalled her experience, “they gave everybody a one day, a one day education to get us up to speed” (participant 3, line 821) on how to care for three new patient populations.

Participants also described having no training, for example, when caring for “off-service” (participant 14, line 466) populations. There was an increase in patients being sent to the first available hospital bed opposed to the unit most specialized to care for the patient: “every [patient population] would go wherever and their [leadership] rationale was because they weren’t getting patients out of the emergency department fast enough” (participant 3, line 788). This practice failed to “take into account the individual needs of that patient” (participant 13, line 634). Nurses regarded off servicing as another way for the hospital to make money, ensuring all beds were full at all times because the hospital now “sees them [patients] as revenue, not patients but as revenue” (participant 9, line 67). Participants recalled, “getting more off service [patients], but we didn’t know how to manage them” (participant 14, line 466), noting they were “not trained on those conditions, on those medications, we’re not trained on those protocols” (participant 6, line 196). Lack of education and training left nurses feeling that leadership “didn’t give us the appropriate tools” (participant 3, line 827) to adequately care for these patient populations, which then left nurses feeling “not well equipped to take care of them” (participant 13, line 193). Participants felt that caring for off service patients with little or no training was “doing them [patients] a disservice” (participant 13, line 195).

Nurses described training for technological changes (intravenous pumps, electronic documentation, medication cabinets) as “rushed” (participant 3, line 704), “inadequate” (participant 5, line 514) and did not address the potential “what if’s” (participant 11, line 622) that could arise should a nurse need to troubleshoot. A contributing factor to nurses concerns

regarding the adequacy of training was an ongoing shortage of nursing staff resulting in nurses' inability to complete training:

You'll be on training and they'll pull you...they want you to work somewhere because they're short staffed so you'll get taken away from where you are and have to work that day instead, so that is difficult, because you don't get the full training (participant 1, line 701-708).

Data suggests that the lack of preparation and training did not only impact nurses within the hospital, "Pharmacy was supposed to be a huge resource [for troubleshooting the medication cabinets] and we would call them and they would say 'we didn't even get the training that you guys [nurses] got', which really blew me away" (participant 4, line 435-437).

Participants noted the lack of support for troubleshooting multiple electronic changes outside the hours of nine to five, Monday to Friday: "what's going to happen at 3 o'clock in the morning [when the technology breaks] and I don't even know how to make it work?" (participant 4, line 197-199).

When nurses asked for additional training or resources to support a culture of care during change initiatives they were "meant to feel guilty for asking and getting what we need [resources] to take care of our patients" (participant 13, line 816-817). Participants felt nurses "shouldn't have to feel guilty" (participant 13, line 816) and that leadership had a responsibility "to provide us with enough nurses to provide good care" (participant 9, line 1111):

The bottom line is, if you gave us the staff, we would do it [provide care as opposed to service]. But we don't [provide care], we go "hurry, hurry, next, next"...that's not how we should be seeing our patients (participant 9, line 1112-1119).

Cuts to resources meant that nurses "get the job done, but you don't get that holistic nursing care that we are promising our patients" (participant 5, line 389). Changes impacted nurse-patient relationships, nurse-family relationships, nurses' community of practice, as well as nurses' relationship to the self. The ways in which these relationships were altered in light of

changes signified a loss of a relational ethics of care, which contributed to a questioning of, and reshaping of nurses' identity.

### **Loss of Patient Caring Activities**

The nurse-patient relationship was impacted by alternations to the ways in which nurses were (un)able to engage in specific patient care activities. General decreases to the time and resources available impacted how nurses regarded their patients. They were no longer seen as "a whole patient" (participant 7, line 290), but rather a "to do list" (participant 7, line 285):

I no longer see my patient as a patient, I see them as a "to do" list. I'm in your room, I want to get this, this and this done, so I can go see my next to do list in the other room. Your day becomes so focused on getting your tasks done that you completely lose sight of the patient (participant 7, line 285-288).

Caring activities that went above and beyond task execution, for example, "cuddling babies" and providing "bed baths" which supported "constant reassessment, constant appraisal" (participant 5, line 120), and facilitated the "building of therapeutic relationships" (participant 14, line 140) were lost. Nurses no longer engaged in these activities because they did not have the time: "because of all the changes that have occurred I'm not able to give them [patients and families] the time they need" (participant 13, line 240-241). Giving time to families to build trust and therapeutic relationships, was, to participant 13, "part of the treatment" (line 218). Additionally, many of the previously described care activities (cuddling babies, providing bed baths) now fell under the portfolio of unregulated care providers, such as "health care aids" (participant 14, line 145). This shift in care providers meant that nursing workloads no longer took into account these activities. The institution delegated these caring acts to "someone else who is paid less to do it" (participant 14, line 138). This fostered trepidation about the "impacts on the care" (participant 7, line 282). Participants were "afraid we lose some of that emotional connection that we build and the trust that we can build with patients and their families" (participant 14, line 147-148). Changes to nursing care were "not healthy for the patients, it's not

healthy for the families” (participant 13, line 221) because “you don’t build the level of understanding, that comfort that they should be able to feel” (participant 13, line 222).

Participants noted that these changes to caring activities occurred over time as the institution shifted from a culture of care to a culture of service, “A number of years ago when staffing numbers were better we would have time to sit and talk to the family if they had questions, or were emotional...I could make sure they’re doing okay and their questions were answered” (participant 10, line 81-83). Now participants “walk into a room, a mother might be crying and I don’t have time to talk to her...I’ve got no more that 3 to 5 minutes to spend with her because I have to go to my other 3 rooms, 3 patients and do assessments and get meds into them and start any [specialized treatments]” (participant 10, line 87-90).

Patient care activities were also impacted by the previously discussed loss of experienced and inexperienced nurses and cuts to nursing jobs, “when you cut 50 nurses, you can’t give the same quality of care, you cannot” (participant 9, line 1830). The remaining staff juggled multiple responsibilities including mentoring inexperienced nurses, “you’re pulled in so many ways” (participant 13, line 214). This was troublesome because patient care activities suffered: “but then you don’t have the time to spend with your own patients, which you’re supposed to be caring for” (participant 13, line 215-216). Caring activities that nurses were sacrificing including building trust and establishing and maintaining therapeutic relationships: “we can’t give them the time they need to be able to ask questions or deal with issues they may have” (participant 13, line 216-218).

Specific technological changes impacted patient care because nurses’ diverted time and attention away from patient care activities to “focus on how to work all the [electronic] systems” (participant 14, line 48). This redirection of time, specifically to electronic charting “did impact patient care...you spent too much time in front of the computer when you could be doing more patient care” (participant 14, line 52-53). Even when nurses were in the midst of patient care

activities, it was noted that they spent much of their cognitive energy thinking about how much of their work now must be entered into a computer:

With the electronic charting, even if you're just sitting there [patient room], you're still thinking the whole time, "I've got to input that, I've got to get it in [to the computer]". So, it's on your mind, knowing you have to get up at some point to do it (participant 6, line 365-367).

This differed from the previous paper charting system, which was at the bedside, "If you had the paper chart you could be there just jotting things down while you're there sitting and talking to the parents" (participant 6, line 362-363). Another participant hypothesized that the therapeutic connections between nurses and patient families were weakened by the cognitive preoccupation associated with electronic documentation, "perhaps a parent might be able to tell their story in a setting where they don't feel like the nurse is itching to get away after she's done her care to document" (participant 5, line 394-396). Participant 5 noted this preoccupation was amplified by the multitude of patients nurses were responsible to document on, "because by George, there's another patient to see after that and more documentation after that" (line 396-398). In addition to feeling that changes mentally separated nurses from patients, participants' experienced physical separation that negatively impact patient care activities.

The location of computers for electronic documentation forced geographical separation from patients. Computers were centrally located at the nursing station or, for some, were located in the anterooms of patient rooms; a small alcove separating the patient room from the unit hallway. Computers were in areas that obscured nurses' views of patients, "where the documentation tool was situated they [nurses] couldn't see their patient" (participant 4, line 275). Some nurses "weren't comfortable" with this change (participant 4, line 279), because "they were used to sitting at the very end of the bed and looking at them [patients]... you couldn't even reach out and touch your patient to calm them from where you had to document, that was

really tough” (participant 4, line 275-281). This activity reflected a culture of care and was lost in light of the architectural adaptations required to support electronic documentation.

The disruptions participants described when managing technologies impacted patient care because they also disrupted patients. Often nurses needed to enter patient rooms multiple times to initiate one of the programming steps required to administer medication via the intravenous pumps or to attend to alarming intravenous pumps. These actions caused ongoing patient disruptions, contradicting participants beliefs about clustering care and providing “developmentally sensitive care, so minimal noise at the bedside” (participant 5, line 659), which were care delivery strategies nurses used to facilitate rest for patients and families. Multiple disruptions were “terrible for the families, especially on night shifts, because you would just have constantly beeping pumps” (participant 13, line 560-561) which created situations where “parents weren’t getting any sleep, patients weren’t getting any sleep” (participant 10, line 454). Participants deemed this problematic because the disruptions “impacts their health, their mental health as well” (participant 10, line 455).

The numerous changes to nursing workflow required to adapt to multiple change initiatives constrained nurses’ ability to provide quality care, “people are impacting change and inflicting changes on us that affect our ability to provide quality care at the bedside” (participant 5, line 1070-1071). Quality of care delivery “dramatically dropped” (participant 10, line 73) following the hospitals shift to a culture of service, “there’s a massive difference in the quality of patient care that we are able to give to our patients and families from when I started to where we are now” (participant 7, line 74-75). Participant 2 also noted this change over time, “I’ve been nursing for over [X] years and I can tell you that the standard of care the patients are receiving now is way less than the care the patient was receiving 25 years ago” (line 550-552). Nurses now determined a shift as “successful” (participant 9, line 1626) if “no one died” (participant 9, line 1626), nurses felt they were “constantly running from behind trying to catch up and make sure someone actually doesn’t die because you’re that close” (Participant 9, line 1627-1628).

Participants noted that nurses were “stretched as far as we can possibly stretch without breaking” (participant 9, line 514-515) because they were working harder than ever to maintain a standard of care in their workplace that they knew was “going to crash eventually” (participant 2, line 20). That standard of care crashed “this year” (participant 2, line 20). The breaking point participant 9 spoke of, and subsequent crash participant 2 spoke of appeared to reflect the tipping point at which nurses “have stopped focusing on care, on education, on teaching” (participant 9, line 75). Nurses used to “give reassurance to families, we would take time and explain to them that ‘these [tests and procedures] are routine things, we get this [diagnosis] everyday, this happens a lot, you’re not the first one’” (participant 9, line 103-105) but “we don’t do that anymore” (participant 9, line 94). This experience was not unique to one area of practice: “Nursing [as a profession] is changing, it’s not as much bedside nursing, it’s more about performance and less about giving holistic care” (participant 2, line 116-117).

All of the activities that distracted from patient care and were changing nursing were metaphorically understood to be “like a pyramid, the child is up there and you keep putting things in the bottom, you’re getting farther and farther away from the care. You’re getting farther and farther because you keep adding” (participant 2, line 561-563).

That nursing part, which was the caring part, that’s part of the care that every patient deserves to have, we are losing that (participant 9, line 120-121).

### **Intensification of Patient Safety Concerns**

Participants perceived a sharp increase in patient safety concerns associated with multiple change initiatives, noting “there seems to be a lot of mistakes in the last 2-3 years” (participant 10, line 146). Increased patient safety concerns were created by a complex interplay of factors. Nurses felt “the workload is increasing and it’s coming to a level where it’s unsafe” (participant 7, line 271), and where, “I’m going to forget something, I’m going to make a mistake” (participant 14, line 96). Participants suggested that because “there are so many things we’re concerned about, we miss things” (participant 5, line 246), citing an increase in “errors,

medication errors, you forget to do a procedure, forget this that or the other thing” (participant 6, line 239-240).

In addition, nurses were often “missing your breaks, you’re not eating, you’re run off your feet” (participant 7, line 279) which resulted in nurses “getting tired, you’re getting exhausted” (participant 7, line 280). Participant 7 further deducted that “with all those factors combined you lose your ability to critically think and that’s when mistakes start to happen” (line 280-281). Participants sadly recognized this new norm was a result of budget cuts: “that’s reality these days with all the budget cuts, we just have to learn to function on bare minimum but it doesn’t make it right and I think nothing will change until something drastic happens, really, really drastic” (participant 11, line 329-331), drastic referring to a severely negative patient outcome.

The loss of experienced nurses contributed to increased patient safety concerns. The loss resulted in many junior nurses, “the scary part for me is that I come in and I’m the only senior staff and the rest of them are junior” (participant 12, line 339). This staffing situation meant inexperienced nurses were responsible to care for highly acute, unstable patients out of necessity but they lacked the “calmness” (participant 13, line 841) of experienced nurses. Inexperienced nurses became “overwhelmed quite quickly” (participant 12, line 348) because “they haven’t had any emergency situations where they’d had to deal with something” (participant 12, line 347), which, for participant 12, meant inexperienced nurses “can’t handle what they’re doing” (participant 12, line 350) in those situations.

Experienced nurses took with them years of organizational memory, which appeared to act as a safety net to ensure past errors were not repeated. Organizational memory can prevent harmful events from being recreated. When those experienced individuals left the organization “no one remembers the historic” (participant 8, line 258), there’s no longer someone to say “we’ve been down this avenue...there’s already been an error” (participant 8, line 287). Nurses in the study believed that “through the travels of time, things get forgotten” (participant 8, line 255). For example, one of the issues nurses brought forth at the daily unit meeting was that

nurses did not have easy access to nasogastric tube adaptors when providing patient care. Remembering that individuals present at the meeting (both regulated and unregulated health professionals) were expected to volunteer to resolve unit problems, a team member who did not insert or manage nasogastric tubes volunteered to find a solution on the tenants that “I’m going to be a good team player and I’m going to make a resolution to this” (participant 8, line 290). The resolution involved placing nasogastric tube adaptors onto nurses’ intravenous carts. Unbeknownst to the team member resolving the concern, the same placement of nasogastric tube adaptors years prior resulted in a critical event where a nurse grabbed a nasogastric tube adaptor and erroneously “luer locked it into someone’s central line and pushed oral Tylenol into a central venous access line” (participant 8, line 286-287), which is strictly contraindicated. It was not until days following the implementation of the unregulated health professionals’ resolution that participant 8, having years of organizational memory, flagged the danger of the solution. Participant 8 found the nasogastric tube adaptors on their intravenous cart and alerted management, “you can’t put those little adaptors there!...That’s another error waiting to happen” (line 298-305).

Participants worried that “solutions are being made not based on evidence” (participant 8, line 314), but rather on whatever knowledge the individuals attending the daily unit meeting contributed. This example serves to highlight how the division of labor among multiple individuals can contribute to errors and omissions, noting “the health care aid doesn’t do that job [nurse], so they don’t know” (participant 8, line 305), they were just trying to be a “good team player” (participant 8, line 290).

The placement of patients in the first available hospital bed as opposed to the most appropriate specialty area also compromised patient safety: “there’s been incidents...incidents of medication errors or patients not doing so well” (participant 14, line 461). Nurses were increasingly caring for “overflow patients...getting a lot of diagnoses we’re not comfortable with, because we don’t work with them” (participant 14, line 467), which was not accompanied by

additional training or supports. This meant that nurses “didn’t know how to properly manage them...there were a lot of patients that weren’t managed properly” (participant 14, line 464) which resulted in some patients “decompensating, taking a turn for the worse and being sent to the intensive care unit” (participant 14, line 471).

Increasing reliance on floating practices to address ongoing staffing issues was perceived as another compromise to patient safety, because:

If you’re not providing the best available nurse for the patient population you’re putting the patient at risk...we see it all the time when we get floating nurses (participant 11, line 400-404).

Because floating nurses were often not comfortable with the patient populations they were assigned to care for, it was said, “patients get neglected, we have found that time and time again when they are given to the floats” (participant 5, line 778-790). Floating was perceived as unsafe, “if you float somewhere else where it’s not your expertise it’s not safe” (participant 14, line 585), “quite simply it’s [floating] very dangerous” (participant 6, line 194). Floating was perceived as unsafe and dangerous because, “We’re going to a unit where we’re not trained on those conditions on those medications, we’re not trained on those protocols...we don’t have the knowledge to provide professional nursing care” (participant 6, line 195-197). This created situations where participants felt “out of your comfort zone, you’re being throw into it [new unit with different patient populations] (participant 14, line 545-546), which differed greatly from their experiences of nursing on their home units. Nurses working on their home units felt they were “used to providing expert care at a certain level with the knowledge they are constantly updating...then you go somewhere where you have no level of expertise” (participant 5, line 460-467). Participant 8 suggested, “when you start taking people of their comfort zone, you’re no longer getting exceptional nursing care” (line 165). Nurses noted that when floated to units that were not their area of expertise, they felt that, “I don’t know what I’m doing” (participant 1, line 583) because “they don’t understand [the types of patients and care required]” (participant

2, line 639). When floating, participants questioned, “What was I going to do? How do I nurse there?” (participant 5, line 459). Often nurses who were floating felt unable to make patient care decisions: “we need to make a decision about this [intervention or care activity], how can a float do that?” (participant 5, line 822). Participant 5 questioned, “How can someone from another unit do that, they don’t know what the hell happened a week ago [treatment and interventions], or where we even were [with patient progress] a week ago” (participant 5, line 823-825). The result was that patients experienced delays in interventions or care activities.

Dispersing care activities to multiple professionals that historically resided in the hands of one provider was seen as risky to patient safety. This change meant, “having more pieces, it’s adding more links to the chain” (participant 14, line 154), which was “just adding more to that hierarchy and then you’re going to miss more, that’s how you start missing more and more” (participant 14, line 155-156) because “a chain isn’t as strong, there’s more points for mistakes” (participant 14, line 156). Rationale for the dispersion of care activities was said to be enhanced patient safety, however participants noted that, ironically, some of the changes decreased nurses vigilance because they fostered a false sense of security. One participant “noted a huge jump in medication errors” (participant 8, line 42) when pharmacy took over the task of medication preparation. The “transition from us [nurses] doing everything ourselves [regarding medication prep] to pharmacy doing it, putting it in a cabinet and us just scanning it, created a false sense of security” (participant 8, line 49-50). Nurses “weren’t checking [medications] as closely anymore when they were pre-labeled” (participant 8, line 32). There appeared to be an increased reliance on other professionals doing their due diligence to catch errors before medications made it to nurses, participant 8 speculated, “we may have got a little comfortable with pharmacy doing it?” (line 36). The origins of this false sense of security were unclear, “I don’t know why all of the sudden we would go to being very hyper vigilant almost to laissez-faire” (participant 8, line 40), with this participant honestly recalling “I even caught myself not doing the double and triple checks” (participant 8, line 41), noting “I’m not alone here, I know I’m

not alone, just the increase in incident reports related to medication errors” (participant 8, line 42).

The ramifications of some of these errors for patients were that “sometimes the medication dose would have changed overnight, and nurses would still take the [pre-filled] syringe [from the previous day] and give the whole syringe [of the previous days dose]” (participant 8, line 44). Participants also felt that medication preparation, a role that was traditionally nurses “we used to mix our own meds all the time” (participant 6, line 104), ensured nurses “had to be proficient in math” (participant 6, line 105). Proficiency in math provided nurses confidence, knowing that “by doing that [math calculations] all the time you’re ready for emergencies” (participant 6, line), which required nurses to quickly calculate and administer medications from stock dosing packages, which, in emergencies, are not patient specific. Redirecting medication preparation to pharmacy made nurses feel that “if you’re in an emergency you’re not going to know what to do or you’re not going to be that proficient at it [math] because it’s something you’re not used to” (participant 6, line 109-110).

In some areas nurses were to disperse care responsibilities to family members for example, the monitoring of a child following an anaphylactic reaction. Parents were given “a little restaurant buzzer thing” (participant 2, line 911) following initial treatments and patient stabilization and directed to the hospital coffee shop or shared play areas throughout the hospital because “there’s no room for them [no beds available in the department]” (participant 2, line 916). Parents were to report back to nurses, “you need to come back every hour for us to reassess’...when the nurse phones the thing [buzzer] and the thing [buzzer] beeps come back” (participant 2, line 914-915). It was now the parents’ responsibility to assess for a rebound reaction between the hours they were to report back to the nurse.

Multiple interruptions to care activities combined with the cumbersome and “shattered” (participant 5, line 101) nature of electronic charting contributed to increased patient safety concerns. Participants recalled frequent interruptions to their documentation activities to attend

to multiple other technologies. Nurses had to leave their charting activities at least “3 or 4 times” (participant 5, line 667), per medication to attend to the intravenous pumps which “interrupted that time I wanted to get some kind of computer charting done” (participant 5, line 668).

Participants noted that because of the centralized location of the computers, nurses were more visible to physicians and other members of the interdisciplinary than previously, when much of their documentation occurred at the bedside. As a result, nurses were frequently interrupted for information requests from physicians, “they don’t know where to look for information [in the electronic documentation system] so they come and ask us a lot, they interrupt us, which again interrupts our workflow” (participant 13, line 520-521). The multiple cognitive interruptions worried nurses, who “know it’s all about patient safety, I realize that is a primary concern of all of ours” (participant 5, line 669-670), but questioned, “how safe is it for me to go in and out [of the electronic documentation system] 3 times, ‘am I charting about this patient or that patient?’ I wouldn’t know because it looks all the same on the system” (participant 5, line 669-670). In addition to interruptions, nurses also had to deal with malfunctions of technology that had the potential to compromise patient safety. For example, participant 7 described an incident where the medication cabinet “failed to dispense the medication” (line 112) needed to managed a patients violent behavior in an emergency situation and another incident that involved the “wrong medication” (line 115) being dispensed “in the pill package” (line 115).

The inability to manipulate technology resulted in multiple critical events involving patients. The notion that nurses did not require education regarding troubleshooting stemmed from leaderships beliefs that technology could never be wrong, and thus nurses would never be required to bypass the smart technology embedded into recently implemented equipment. Of particular concern were the new intravenous pumps, “the new IV pumps are a safety issue” (participant 11, line 589). One participant recalled not being able to override the infusion rate limits on a smart pump when a patient required a medication dose higher than the pump

recognized as safe. The inability to override the pump compromised patient safety, “the pump contributed to an instability in the patients blood pressure” (participant 11, line 587), which “nearly killed the patient” (participant 11, line 586). Participants recalled this same issue (not being able to override the infusion rate limits) when patients required a bolus of fluid (large amount of volume instilled over a very short period of time): “we couldn’t run things fast enough” (participant 11, line 629). This participant abandoned the use of the pump and reverted to manually administering the intravenous fluids, as she deemed this intervention “safer” than “hoping I know how to work the pumps and all the error and alarm messages” (participant 11, line 631-632). Another participant recalled a similar event where nurses were unable to “administer a fluid bolus in a timely manner” (participant 4, line 180). Troubleshooting efforts were unsuccessful, “even our own educator, who was one of the expert resource people couldn’t troubleshoot, the pharmacist couldn’t troubleshoot” (participant 4, line 177), which created “a critical situation and people were left feeling that safety was compromised” (participant 4, line 188). A major barrier to the manipulation of smart pump technology was that the pumps “always required wireless updates and they come randomly” (participant 3 line 632), noting that “those updates don’t start until you turn the pump on” (participant 3, line 618). This created patient safety concerns when STAT medications were ordered and nurses would turn on a pump to administer the STAT medication “that the patient really needs immediately” (participant 3, line 627) and the pump began the update process, “now it’s saying update needed” (participant 3, line 623). Nurses were unable to bypass or override the updates, so they had to “yell to another nurse to bring you another pump, which isn’t always there” (participant 3, line 635-636). When another pump was not immediately available, nurses must “stand there and wait” (participant 3, line 634) for the pump to update, delaying medication administration. This scenario was further complicated because intravenous pumps were no longer available on units, they were now stored in a central pump room that required nurses to page a porter to bring a new pump to the unit.

In addition to the inability to manipulate technology, participants were concerned about who could and could not access medications locked in the medication cabinets. Login required “a biometric finger print” (participant 5, line 637), whereby “only nursing and respiratory therapists have access” (participant 11, line 550-554). Previously, anyone who had a swipe card programmed with permission to enter the locked medication room for example, physicians could be tasked with retrieving any patient medications. Physicians no longer had access to medications, which for participant 11 “is another big safety issue, that the physicians don’t have access to the medication cabinet” (line 553), noting that “when in a crisis is a real problem” (line 554).

Increasing reliance on smart technology was perceived as a threat to patient safety. Some nurses, most often described by participants as newer graduates or nurses within their first few years of practice, relied heavily on technology to calculate and verify safe and accurate medication doses and infusion times. One participant recalled running a mock scenario with younger nurse colleagues (referring to nurses who had entered nursing after the introduction of smart technology) where she pretended a patient’s intravenous pump malfunctioned and the nurses were to calculate the dose and infusion rate for a continuous medication infusion. The participant noted her colleagues were unable to do so, saying “uhm, ok, ok” (participant 2, line 401), fumbling through the “medication monogram” (participant 2, line 401). One participant suggested younger nurses “just say, ‘well the pump says to do it at this rate’” (participant 11, line 638), relying solely on the pump for confirming accuracy and safety. Experienced nurses warned that “you have the computer, but if the computer isn’t there you won’t know how to do it” (participant 2, line 404), often questioning, “If the technology isn’t working, what are you going to do in the interim?” (participant 11, line 648). Participants were concerned about patient safety when nurses were unable to do safe dosage and administration calculations without the use of smart pump technology and computers because, according to participant 11, “there are still discrepancies with them [the pumps] and you can’t rely on them” (line 647).

Participants explained that the change in mentality they were seeing in younger nurses was in light of a larger, societal shift, “I think it [reliance on technology] is a much grander scheme” (participant 11, line 574), suggesting that “when the technology becomes so advanced and fast, young nurses change with that [change]” (participant 2, line 130). Generational changes encompassed younger nurses relationships with technology “that generation is all electronic now, they’re all about computers, so the mentality of this generation has changed” (participant 2, line 125-127). Technology was perceived as “new toys” (participant 2, line 383) to this generation of “digital babies” (participant 5, line 431), who were part of a generation that now “spends their entire lives [using technology] to code what their mood is, their heart rate, when they get their exercise, and how many miles they’ve walked” (participant 5, line 1225-1226). Older nurses cautioned this generation “I don’t think they realize the kind of damage these things [technology] can cause” (participant 2, line 385) when they are relied upon in lieu of basic nursing skillsets, “I don’t know if they know what they’re missing, do you really know what you’re not doing?” (participant 5, line 434-444). Examples of “not knowing what they’re missing” included not manually calculating the safe and accurate medication doses and infusion time, “look at these poor young nurses, no clue how to calculate intravenous medication doses...and then they have to use a dilution calculator [to calculate final concentration]” (participant 2, line 435). These tasks, when calculated manually, were said to be completed using “common sense math skills” (participant 2, line 437) that, historically have been completed by nurses with paper and a pen. Participant 2 offered insight into this shift from manual verification to reliance on technology, “you can’t fault them [young nurses for not knowing]...before you had to do everything when calculating, now everything is done by computers so they don’t know how to calculate meds” (line 124-126).

This reliance on technology appeared to extend beyond nursing. Participant 5 recalled telling a younger physician “this patient is having very subtle seizure, I think we need to look a bit deeper” (line 743). The nurse reported “subtle hand twitching and sucking noises” (line 737),

but recalled that the physician “didn’t even look at the patient, they looked at that bloody monitor and if they can’t find evidence [of seizure activity], then it didn’t happen” (line 737).

Subsequently the patient’s condition deteriorated in the hours to come and received their first dose of seizure medication six hours following this nurse-physician transaction.

### **Fracturing of the Nursing Community of Practice**

Nurse’s communities of practice were impacted by rapid and continuous organizational change. Multiple impacts of rapid and continuous change created stressful work environments, “every day that we [nurses] come to work is stressful, we’re so stressed” (participant 9, line 278) and environments that no longer fostered teamwork. Over time this took its toll on working relationships, “it [work environment] doesn’t make for good working relationships or teamwork” (participant 8, line 91-92), which for many participants, “makes it quite hard to work there” (participant 1, line 472). Participants described five factors that contributed to the fracturing of the nursing community of practice: architectural influences, hyper attention to technology, loss of traditional charge nurse role, overburdened nurses and social disengagement.

The first factor was certain architectural changes that no longer fostered teamwork, for example, the creation of more isolated single occupancy rooms or pods structures. These changes meant “the unit is brighter, it’s cleaner” (participant 5, line 212), but “we have lost something, and that something is, ‘well I don’t really know what’s happening next door’, we’ve isolated ourselves with our own patient assignments” (participant 5, line 221-222). The change in some units configuration “has led to more privacy, but its also led people to be more disconnected” (participant 5, line 1223), the “unit culture had to change to adapt to the architecture” (participant 5, line 221. Nurses’ relationships changed because they no longer worked as “closely together, as a team, as a unit” (participant 5, line 1040). Participant 5 recalled that in the previous architectural configurations, “although we did have separate assignments there was still this feeling of collective responsibility [for patients]” (line 230), however, “now nurses think this is their assignment and that’s all there is to it” (line 219).

The second factor was hyper attention to technology. Participants suggested that because “we’re so honed into these computers we’re ignorant to everybody around us” (participant 8, line 94), which contrasted with experiences prior to electronic documentation, “when we didn’t have our heads in computer we would see our friend [nurse friend] running up the hallway, and we’d yell, ‘hey do you need a hand’” (participant 8, line 96-97). Nurses were “not as aware of the people around us” (participant 8, line 98) due to the need to be on a computer so frequently.

The third factor that emerged from the data was associated with eroding teamwork between frontline nurses and charge nurses. Nurses explained the new, more administrative roles of charge nurses, which saw charge nurses more removed from clinical practice, “I’m completely taken away from the bedside and mentor support, to man the desk, the phone, I’m going to committee meetings and staffing meetings” (participant 8, line 281-282). Charge nurses were now working closer with management than nurses creating tension: “they [frontline nurses] were angry at us [charge nurses]” (participant 8, line 767), because they were no longer as visible on the unit, “we [charge nurses] weren’t there” (participant 8, line 769). The restructuring of charge nurses work meant they “couldn’t be there for them [frontline nurses]” (participant 8, line 381), to offer “mentor support” and other means of support, for example “we couldn’t relieve them [frontline nurses] for breaks” (participant 8, line 769). Additionally, because the charge nurses were now more aligned with management, they were implicitly expected to openly support leadership decision-making, while often frontline nurses did not. This was difficult for charge nurses because, “none of their [leaderships] rationales made sense” (participant 3, line 785). This tension saw some charge nurses leave those positions and return to frontline nurse positions because “I can’t support leadership...I would just be lying to the nurses, so I jumped ship [left the charge nurse position]” (participant 3, line 810). This participant explained her experience as mirroring that of the battle of Gallipoli, “I call it the battle of Gallipoli, I can’t support them [leadership], I gotta go, like the officer, couldn’t support his men from being

slaughtered by the Turks so he went over the wall” (participant 3, line 808-810). Another nurse who gave up their charge nurse role and returned to a frontline nurse position recalled having their “shoulders completely unburdened” (participant 8, line 799).

Overburdened nurses was the fourth contributing factor. Increased workloads made it difficult to ask for help and some nurses felt that asking for help negatively impacted working relationships: “other nurses are busy at the same time and if you go ask for help then you delay other nurses in their work” (participant 14, line 63-64). Asking for help “affects your relationships with your coworkers” (participant 14, line 64) because the nurse asking for help is seen negatively by colleagues. Nurses “won’t ask [for help] because older nurses are getting so snarky” (participant 8, line 287), with comments like “she should be able to take on her patient load herself” (participant 14, line 67). Nurses no longer had the time or motivation to support each other, “I don’t think the motivation is there anymore” (participant 8, line 346). Participant 13 recalled, “I thought I was really supported when I first started as a nurse, I don’t feel that I can give the same support to staff now” (line 438-439). Participant 8 echoed a similar sentiment, “I had the most wonderful mentors and people to support me when I started nursing...they [newer nurses] don’t have that support now” (line 290-297). Nurse participants suggested that the rationale for this change over time was twofold: the increased workload and demands on nurses left no time for mentorship, “they [nurses] just don’t have the time” (participant 8, line 346), and experienced nurses were no longer investing their time and efforts into inexperienced nurses because, as a result of changes to staffing practices, “the nurse lasts 6 months and then they’re gone...why bother [mentoring]” (participant 8, line 348). Many newer nurses left the organization early into their career to pursue other career opportunities or further their education, “I’m going to get my masters...because this [bedside nursing] isn’t what I thought it was going to be” (participant 5, line 118) or because they have “floated around the hospital for 2 years because that’s all they could get” (participant 5, line 115).

Changes to staffing practices and a lack of mentorship and support from experienced nurses meant “a lot of new graduates nurses struggle when they’re learning to be a nurse” (participant 8, line 182), which saw “newer nurses dislike their job, certainly they learn to dislike it a lot quicker [than experienced nurses]” (participant 8, line 289). Inexperienced nurses “don’t find their go to people quick enough, it’s very hard for them to find them” (participant 8, line 307), which left inexperienced nurses in positions where “they feel very lost and very alone” (participant 8, line 308). One participant noted that because of the impacts of multiple change initiatives, nurses “build up at the back of your mind a subconscious resentment that comes out in other ways” (participant 13, line 415). This subconscious resentment came out in “interpersonal relationships with other members of the team” (participant 13, line 420), which “causes animosity between different people in the same unit, even between nurses, you become short with each other” (participant 13, line 421-422), and negatively impacted nurses communities of practice.

Nursing communities of practice were often developed and maintained through social events that took place outside of the workplace. The erosion of social events was the fifth factor contributing to the fracturing of the nursing communities of practice. Social events outside of work became almost non-existent, which meant, “the social connections that people have outside of work are frayed, there is a closeness amongst the team that isn’t really there anymore” (participant 9, line 702-703). Participants recalled, “there used to be a lot more social events” (participant 9, line 693), including “baby showers” (participant 6, line 353), “open houses...retirement parties...bowling nights” (participant 9, line 692-717). It now seemed that “everyone has curled in on their own and nobody is making those connections” (participant 9, line 721) because “work is so hard right now, work is so stressful...work is too much, they [nurses] don’t want to do anything after, work is work and when I’m done work I don’t want to see those people” (participant 9, line 700- 719). Building strong communities of practice

required colleagues to think about each other outside of work, which for many participants used to be the norm, however that had now changed:

You know it takes time to think about your colleagues [outside of work] and now when you're outside of work... people are just feeling like, it's work, I can't do anymore work, I'm done, I'm done with work...now I go home and put my feet up, put a cat on my lap and drink a glass of wine, don't ask me to think [about work or colleagues] (participant 9, line 733-816).

One participant noted that "we've lost that sense of [being a] team" (participant 8, line 371). Nurses were not developing the same friendships as some time ago, "the connection isn't there...there's not as much joking, there's not as much fun, there's not as much singing and laughing" (participant 9, line 808-810). This lack of connection partially explains why there was less mentorship and collegial support amongst nurses.

Experienced nurses worried about changing communities of practice as they foresaw the negative impacts this loss could have on inexperienced nurses who were just joining the profession, "I don't think it's [nursing] feeding our younger generation of nurses...maybe I'm being a romantic here, but I'm really afraid that our younger generation will not get out of it what we have and that makes me very sad" (participant 5, line 447-491). The environment that shaped nurses work lives resulted in widespread job dissatisfaction, where "morale was at an all time low" (participant 9, line 521).

### **Dismantling of a Nurse's Identity**

That's soul destroying, those people [nurses] who do a tremendous, wonderful job are being told, "could you be faster, because it would make us more money". That's not what we went into nursing for, that's not why we should be in nursing, that's not what it's about. It's discouraging when you hear that, that's not what we're supposed to be about, that's not a positive change in any way (participant 9, line 1569-1573).

Nurses underwent rapid and continuous change that created an unsettling norm. Witnessing the various impacts on patient care activities, patient safety, themselves and their own community of practice signaled, for many, that nursing was changing. Participants struggled with the dismantling of nursing's identity as a result of multiple change initiatives that restructured and increasingly governed how they were to nurse.

A changing nurse identity was shaped by ongoing experiences of perceived failure, devaluing of nurses in their workplace and deskilling practices. These experiences caused nurses to question their sense of self-worth and belonging within their HCO. Participants felt failure in two ways: that they had failed their patients, and that they had failed themselves and their commitments to the profession of nursing. Nurses felt they were failing patients when they were unable to deliver care activities that supported a culture of care, "I feel like I haven't fulfilled what I needed to do, and I could have given more time to that patient" (participant 8, line 84-85).

Attempts to deliver timely care activities were often thwarted by tedious manipulation of multiple technologies, "you think, "Oh, I'm stupid, I can't do this right, now this [medication] is late, my patient is in pain and I've had to wait to get this medication out of the cabinet" (participant 4, line 445-446). The patient care documentation system also fostered feelings of failure. "I've left behind a stream of what I believe is inadequate documentation about patients I have taken care of" (participant 5, line 591). Instead of blaming faulty technology for failing patients, nurses blamed themselves, "why aren't I working right?" (participant 4, line 465).

Nurses felt that no matter how hard they worked, they were "somehow failing to meet the departments expectations" (participant 9, line 1653). This was intrinsically woven into their self worth, "which makes us feel like we're failing our own [expectations]" (participant 9, line 1654). To meet department expectations, nurses felt pressured to "cut corners" but this contradicted their core values, insisting "you don't cut corners when it comes to patient care" (participant 9, line 391). Nurses had "been made to feel like we're not fast enough, not quick enough" (participant 9, line 1660). The pressure to work faster to ensure all hospital beds were filled and

turned over as quickly as possible was immense. When nurses could not meet the targeted admissions and discharges set by administration, despite previously noted losses of time and resources, some nurses felt that:

At the end of the day due to no fault of my own I feel that I have completely failed [because] I haven't gotten beds [available for patients], I haven't gotten patients [assessed] in a timely fashion...I feel just like I've failed, like this day was a failure (participant 9, line 1622-1626).

Changes left nurses unsure if they were doing things properly, "you always second guess what you're doing, 'oh is this the way we do it now, is this the new thing?'" (participant 12, line 457), which took a toll of nurses confidence, "you think, 'Oh, I'm stupid I can't do this right'" (participant 4, line 465). Resultant feelings were that leadership deemed them stupid, "you feel like they [leadership] think you're stupid. That's what it comes down to...they don't think you're smart enough [to keep up with the pace of changes]" (participant 14, line 512-513). Participant 11 reiterated how multiple participants felt regarding failure, "No one wants to come home feeling like they've failed" (line 1129).

### **Devaluing**

You don't feel valued or recognized, and your knowledge isn't recognized (participant 14, line 509)

Participants felt that "we're [nurses] made to feel dispensable and like we're not important and that we're not a big part of the hospital's running" (participant 6, line 316). One of the most notable ways in which nurse felt dispensable was the recent announcement from leadership that up to 50 full time nursing equivalent positions hospital wide would be liquidated to mediate a budget deficit. These cuts made "people feel devalued" (participant 6, line 262); nurses questioned "how is the hospital possibly going to work with that much less nurses? We can barely survive now the way we are" (participant 6, line 263). In light of the growing culture of service; "they [leadership] don't care about us [nurses] as people at all. It's money, money,

money, that's their bottom line" (participant 6, line 282). Nurses were especially disheartening because of the multiple ways in which they sacrificed much of their own well-being throughout multiple change initiatives to ensure patients were impacted as minimally as possible:

You give up so much...you miss your breaks, you're run off your feet, you're emotionally exhausted and to know you can just be laid off, it [lay offs] makes it seem like none of that really mattered (participant 7, line 227-230).

The growing belief that "a nurse is a nurse is a nurse", which most notably manifested as increasing floating practices to address hospital wide staffing needs, made nurses feel devalued:

I find it [floating] demeaning...it's like our jobs aren't important. We [leadership] can just throw you anywhere, your training is not important, nothing you've done means anything. You can go anywhere; you're just a body...as long as the space is filled with the body that's fine (participant 6, line 203-205).

Nurses believed that, "every nurse is specially skilled in their field, and those specialties need to be admired, respected and appreciated" (participant 9, line 1458-1459), however it was suggested that the frequent use of floating practices construed to nurses that "they're not [admired, respected and appreciated]" (participant 9, line 1460). The practice of floating minimized the importance of nurses having a unique skillset, "I'm a specialist, and you put me somewhere else, you're diminishing what I can do, you're diminishing my influence" (participant 9, line 1473-1474). Interestingly, this idea of influence links back to the idea that floating compromises patient care because decisions about care are difficult to make for floating nurses who are not familiar with the diagnoses or treatments available. Given this lack of knowledge nurses were less able to advocate for patients, which made them less able to care, as patient advocacy was a component of a culture of care.

Nurses compared the floating role in the profession of nursing to other professions to articulate how valueless this practice made them feel: "you wouldn't take a mechanical engineer

to do a civil engineers job for the day, so they [leadership] shouldn't be taking a critical care nurse to do oncology because it's different [skillsets]" (participant 6, line 188-191). Another participant used the idea of physicians floating to justify why she felt floating in nursing was unjustified, "medical doctors go to lots of areas when they are training...just like nurses, but once they qualify, they specialize" (participant 1, line 557-559), noting that "nobody expects a surgeon to go and work on a medical unit" (participant 1, line 560). This belief about physicians appeared to dramatically contrast the expectations for nurses "we're [nurses] expected to work everywhere" (participant 1, line 562). Nurses felt devalued because their concerns about floating practices had been brought to leadership multiple times, but were not respected, "it's [floating] brought up at all the meetings but it's something I guess the institution doesn't feel is important" (participant 6, line 218-219). For participant 6, devaluing nurses' concerns was "what almost makes it worse for all of us who are floating" (line 220). The ongoing reliance on floating practices to rectify staffing shortages left participant 11 questioning, "Why don't you [leadership] value your nurses' expertise" (line 675).

Nurses noted their feedback regarding change initiatives was often dismissed, which compounded their feelings of being devalued: "don't dismiss us...listen to that feedback...take that feedback seriously" (participant 9, line 1367-2387). Dismissal of nurses concerns left participant 5 questioning, "why do you [leadership] think our opinion is so valueless?" (line 77). Participant 5 felt that leadership rationalized the dismissal of nurses' opinions because they had reduced nurses to "a bunch of bitchy, menopausal, hot-flashing nurses who are fed up with the whole bloody game" (line 990-991). Participant 5 disagreed, "but I don't think we are. I think as a collective we are still very invested in our patient populations, our families, nursing" (line 992-993). Having their opinions and feedback dismissed regarding multiple changes was confusing for nurses: "We're to be trusted with critically ill patients...yet you [leadership] don't want to give us the time of day when we tell you that you are not enabling us to do our job properly" (participant 5, line 77-80).

## Deskilling

They're trying to dictate every single thing we do and not give us a mind of our own, and not give us a chance to use critical thinking (participant 6, line 484-485)

Leadership created a work environment that nurses felt "shrinks the little box in which you have to be" (participant 14, line 419), which made participant 14 "feel trapped in the box they've created" (line 657). The box nurses resided in shrunk for multiple reasons including: the redistribution of nursing work to multiple others (both regulated and unregulated care providers), the increasing reliance on technology, and increasing standardization of nursing work processes, all of which were said to foster deskilling. For example, the loss of responsibility for care activities that were traditionally nurses, such as bathing patients, was now done by health care aids. Bathing patients was "a valuable part of our nursing work" (participant 14, line 142), so was medication preparation, which was now done by pharmacy. Specific change in medication preparation "took us [nurses] out of our role, that was part of our jobs" (participant 8, line 32). The result of the "shrinking box" and lack of encouragement to utilize critical thinking skills created and maintained a culture of good enough, "if you don't have people that take pride in what we do, you're only going to do it half assed, why bother...as nurses we used to take pride in that [our scope of practice], nobody does anymore" (participant 8, line 254-256).

Increasing reliance on technology and other health professionals to do the work that was historically that of nurses appeared to reshape, over time, what nurses were to know and learn. Nurses were increasingly taught to rely on technology and other health professions more than their own skill sets, "we're no longer teaching nurses to think critically outside the box, we're teaching them to rely on pharmacy, rely on the machine, rely on all of that" (participant 9, line 939-941). Thinking "critically outside the box" reflected what some called the "art of nursing" (participant 5, line 110), for example, "knowing that you don't need to bolus your patient with Versed and Fentanyl when you can just change its diaper, or wrap it up tight, or stick a plug in its mouth, that's so basic...but it's gone" (participant 5, line 121-124).

Nurses' growing reliance on technology and other health professionals was "deskilling people like crazy" (participant 11, line 648) as evidenced by nurses who "don't know how to math anymore...basic calculations that nurses need to be able to do and people just don't do them anymore" (participant 11, line 657-658) because "pharmacy makes it [medication] for you and the pump tells you how to administer it" (participant 11, line 650). Nurses believed such practices were the root cause of the lost critical thinking skills they were seeing in nursing practice. They proclaimed the organization was "reducing our [nurses] thinking capacity" (participant 11, line 64). Nurses felt that "our jobs are being taken away...with the more technology that comes along" (participant 6, line 99). Participants struggled to understand why technology was valued and deemed more accurate, than nurses: "why is it that a technology is more accurate than me? That's [monitor and care for patients] what you pay me to do!" (participant 5, line 749-750). Participants suggested nurses had lost "the flexibility in troubleshooting, because everything is handed to you" (participant 9, line 872). This flexibility was directly tied to nurses' thinking ability, noting that nurses "no longer think critically" (participant 9, line 932).

One reason nurses could no longer think critically was the multiple standardization practices that now governed much of nurses' work. The "standardization of everything...takes away from that critical thinking of, 'what is best for our individual patients'" (participant 13, line 631-632). One participant speculated that standard work processes were implemented because, "they [leadership] want us to be little robots and follow this sheet of, 'this is how you do it' and this is how everyone is going to do it" (participant 13, line 344), which "humiliated" some participants (participant 13, line 371) and made them "feel like a kid at school being told to do this and this" (participant 14, line 231). When nurses did not follow standard work processes they were "penalized...if you don't follow it [standard work] you're in trouble" (participant 13, line 363-372), yet, "when I use my critical thinking skills, I don't agree [with standard work processes]" (participant 13, line 363).

Implementing standard work processes did “not take into account that every nurse has a way of nursing, standard work takes that all away” (participant 13, line 345-347). Standardization of work processes was “putting too many restrictions on nurses” (participant 14, line 488) and appeared to be partially responsible for one participant’s observations that nurses were “starting to lose the capacity to think on their feet and be creative, or come up with creative solutions” (participant 9, line 889). Others did not nuance their observations, “nurses are becoming brain dead...we’re becoming brain dead for sure” (participant 2, line 434-440). They observed that they had become “more robotic” (participant 8, line 100) in their practice because of their reliance on technology, “you come in [for your shift], get report on the computer...get your medications from the cabinet...chart your assessments on the computer, your whole day is guided by stuff that needs to be inputted into the computer system” (participant 8, line 101-106). Participants saw nurses slowly shifting into a role where “we’re just going to give pills and do techniques [skills]...and become that kind of machine, just doing the tasks” (participant 14, line 161-165).

A specific change that fostered such a shift in the nursing role was the electronic documentation system. One nurse suggested nurses had been reduced to nothing more than “fucking box tickers”:

I’ll never forget, one of our more outspoken nurses, who’s been there for many, many years finally sat back after it [electronic documentation system] had been on for about a year and said, “you know what we’ve been reduced to?” and I said, “what?” “Fucking box tickers”, she said, “FBTs”, and I thought, “there’s a sorry statement” (participant 5, line 152-156).

This robotic, or machine like nursing, for some, “wouldn’t be seen as being true to myself” because their identity as a nurse focused on “being real...more human” (participant 14, 176). Nurses were “real” and “human” when they were able to foster a culture of care, for example, when they fostered therapeutic relationships and connected with patients and families:

People are letting you into their lives and their situation and actually being vulnerable and saying, “hey we need a hand, could you help us”...I like being able to help and feeling like I can make that difference because anyone can change a bandage, anyone can give a pill, but it’s to find ways to reassure them [patients and families]... to help them the best you can (participant 14, line 180-186).

Nurses perceptions about nursing identity were grounded in a culture of care, however nurses saw their collective identity changing exponentially as reflected in a culture of service. Distressed nurses were drawn into a plethora of negative emotions including: anger, frustration, mistrust and distrust, sadness, worry, and many elements that constitute change fatigue such as apathy, disengagement, exhaustion, burn out, powerless and disempowerment. These emotional repercussions were fueled by moral indignation and felt in response to experiencing the erosion of many aspects of the relational ethics of care that defined nurses in their practice.

### **Intensification of Negative Feelings Emotional repercussions**

#### **Feeling Angry**

I’ve never seen a group of staff so angry before; there was a lot of anger. There was frustration in not being able to do our jobs, anger that we had predicated that these would be the frustrations and even more anger that we haven’t been given any credit for having legitimate concerns (participant 5, line 1214-1217).

Participants were angry in response to a myriad of events associated with change initiatives. Anger was present in the data in three ways. Nurses named anger, “they’re [nurses] angry” (participant 9, line 539), used words to express anger, “pissed off” (participant 9, line 676), “shit” (participant 1, line 1511), “fuck” (participant 9, line 1469), “kick” (participant 5, line 1062). At times participants used language that was accusatory in nature to describe some members of the leadership team as liar(s), “we’ve been lied to so many times” (participant 10, line 374) hypocrites, “I find this kind of hypocrisy breathtaking” (participant 5, line 41). Consequently participants felt “betrayed” (participant 6, line 271). Some participants used the

words “frustrated” and “angry” interchangeably. The findings suggest participants were experiencing the later, so frustration is considered to be part of a continuum of anger. Feeling angry with leadership was associated with multiple factors: disingenuous leaders, financial wastefulness, inappropriate training and education, lack of appropriate nursing resources, ineffective communication venues, disregard for nurses and the inability to provide a culture of care.

Participants were most notably angry when they were consulted regarding the change process, but not for genuine reasons:

Don't ask us if all you want is your tick in the box for accreditation that says staff will be consulted about purchasing equipment, especially hugely expensive ones like that [electronic documentation]. I don't want to play the puppet, don't ask me then. Don't bother (participant 5, line 249-251).

Participant 3 described this notion of nurses being disingenuously consulted as a “smokescreen”: “over and over again, we're not being heard. I call it the smokescreen, they're pretending they're doing something about it [lack of nursing voice in decision making], giving us an avenue to voice our opinions” (line 363-365). Participant 5 alternatively described this kind of consultation as hypocritical, noting, “I do not want to participate in those hypocritical exercises where it is said that staff; user experts, were consulted and in the end it was just about the bottom right hand number” (line 258-260). Another participant recalled being “frequently amazed that no matter how much I would say, this [intravenous] pump is better for nurses than this one, they [leadership] would constantly go for the other one because it was cheaper” (participant 10, line 543-544). Financial wastefulness was the second factor that contributed to participants' anger.

Ironically, multiple change initiatives ended up being “incredibly expensive” (participant 5, line 1298), because, according to participants, many “don't quite fit the bill” (participant 5, line 1298). Many changes required multiple updates or outright replacement. One example was the

purchasing of intravenous pumps. Upon consultation, nurses overwhelmingly supported an intravenous pump that was more expensive than the one the hospital purchasing: “there were many more positive reviews [for the pump that was not purchased]...much higher approval rate” (participant 10, line 368-371). The hospital purchased an intravenous pump, which, for multiple reasons including patient safety concerns, was replaced 2 years following implementation. The pump the hospital purchased to replace was, indeed, “the pumps that we [nurses] originally asked for 3 years ago” (participant 10, line 470). Nurses considered this to be “very poor decision making, If it’s going to cost you an extra million dollars 2 years later to buy all new pumps for the whole hospital” (participant 10, line 501-503). This spending was seen as an irresponsible use of health care funding, and deemed a significant waste, “the IV [intravenous] pumps feel like a waste of money” (participant 6, 138).

Anger also arose from the imminent replacement of the newly implemented electronic documentation system:

In 4 years we’re changing to another [electronic documentation] system, well that’s the silliest thing I’ve ever heard. Why switch, why not start out with that system first because you’re taking that time and energy and the finances to use this system for 4 years? (participant 12, line 84-86).

Nurses were angry because, “now we’re millions of dollars in the hole and don’t tell me that those systems aren’t responsible for that” (participant 5, line 556-557). Nurses noted a multitude of other changes wasteful, including the medication cabinets. Medication cabinets were considered “more wasteful than pouring pills from a bottle because at least before, if you only need half a tab you put the other half back in the bottle, whereas now you just have to throw it out” (participant 7, line 120-122). Conversion to medication cabinets was also wasteful because of the associated medication administration records, which went from being weekly records to daily records, “MARs [medication administration record] come out daily, they print off so much paper, a couple trees” (participant 12, line 102). Lean was also seen to be wasteful,

which angered participant 3, “I haven’t seen anything 100% positive come out of that [Lean], just a waste of a bunch of trees with all those tickets and these boards that cost how much money they had to spend” (line 371-372). Participant 11 explained how the placing of fiscal priorities by leadership angered her:

We’ve put this much money into Lean... the amount of money they’ve even paid for staff to go and see these thing [in other hospitals], I mean patients do not get the priority in this hospital. The priority should be the patients that really urkes me the wasted money that goes into it [Lean] (line 1039-1042).

Participants noted, “there’s a tremendous amount of waste [that has accompanied many changes], any nurse will tell you that” (participant 5, line 30). Electronic changes were said to “come with huge running costs”, which was perceived as “a lack of sense” (participant 5, line 35) amidst the current, tight fiscal environment. Nurses were irate about the wasteful nature of multiple changes, “it’s insane to me that time and resources are spent on those [changes]” (participant 13, line 376). Nurses believed that resources could have been better spent on activities that foster a culture of care, such as “patient care or nurse education” (participant 13, line 378). At a time when the hospital was experiencing a period of strict fiscal restraint and nursing lay-offs, nurses were increasingly angered by the evident waste in their workplace.

Participants were indignant that they had requested additional training in preparing for multiple change implementations, but were instead repeatedly given training that “didn’t give us the appropriate tools” (participant 8, line 827) to effectively manage changes. Inappropriate training and education further contributed to nurses’ exasperation. Participant 3 again described this again metaphorically as “smokescreens” (line 826), noting that leadership believed “oh, we gave them education” (participant 3, line 826), however nurses believed that, “Well no, you didn’t give us appropriate education” (participant 3, line 827). Further, nurses complained that the human resources they requested to provide quality, safe nursing were denied: “don’t give us

shit if we ask to keep a nurse...we have to argue [with management] to justify keeping a nurse...when I need more nurses I have to beg" (participant 9, line 1687-1698).

Participant 9 noted that generally, since the start of rapid and continuous change implementation, "people are a little bitter and pissed off" (participant 9, line 675) as a result of a lack of appropriate nursing resources. Nurses were irritated that no one outside the institution knew or understood the negative impacts of ongoing change, noting that "the [public] image portrayed in and around the city, it's so different from the image of the people who work there live" (participant 6, line 304-306). Nurses were angered when faced with ineffective communication venues. They didn't know where or who to confront about their daily realities, "I want to report it [work conditions] in some way, but I don't know how to" (participant 11, line 347). Participants directed anger towards those responsible for fiscal decision-making and resource allocation, "I want to go talk to the [premier] and say, 'come in and look at our unit'. Talk to our CEO and say, 'get your butt in here, come see what is happening, watch us drown'" (participant 11, line 347-349). This participant was disenchanted by the notion of bringing her concerns forward, "I say that, but in reality they don't have a clue what we do, so it wouldn't do anything anyway" (line 50-51). Nurses anger regarding a lack of effective communication venues was fueled by the way they were informed about imminent lay-offs, "it came out in the news before we got the email from the hospital president, it was on the news before we got the email. So I think [we felt] anger, betrayal" (participant 6, line 271). The ongoing institutional barriers they faced when attempting to meet the moral imperative of providing a culture of care also drove the anger participants felt:

It's frustrating...the thing is that most of our time in our job, most of our day is figuring out failing equipment, organizational issues, all issues other than looking after patients...but that's not why I became I nurse (participant 12, line 381-385).

Participants resented the ways change initiatives altered what constituted nursing work and how that work was carried out, which demonstrated a disregard for nurses. Cuts in funding

fueled their anger: “it’s [cuts] frustrating when you’re trying to provide the best patient care possible” (participant 10, line 72) because the result was less time and resources being allocated to patient care activities, and more time and resources being directed into change initiatives. Nurses’ work became more time consuming and complicated; leaving less time to practice bedside nursing. One example, the frequent troubleshooting of intravenous pumps, was tedious,, “those pumps ring for no good reason, so they’re very frustrating” (participant 3, line 673) and time consuming, which made some nurses feel like they “just want to take the pump and throw it...get rid of this!” (participant 3, line 626-627).

Computers that nurses used for their documentation were “not ergonomic” (participant 1, line 820), which was frustrating for participants because “you would have thought they [leadership] would have at least thought about that” (participant 1, line 821). This annoyance was exacerbated by the fact that nurses were required to “do musculoskeletal disorder training on the computer as part of our mandatory training” (participant 1, line 822), which “tells us how to make everything comfortable so we don’t injure ourselves, but then they provide us with new equipment that is useless for that!” (participant 1, line 824-825).

Participants were irritated by the electronic documentation system for many additional reasons. Some nurses did not think it was a necessary change, “it was just another thing to learn that we didn’t need to...most people didn’t see the problem with paper charting. It worked, it allowed us to spend the time with our patients” (participant 6, line 132-143). Participants were “again told this is the newer technology” but were “not quite sure what it’s going to be better at?” (participant 6, line 135) This made the change “frustrating for everybody” (participant 6, line 133). The time it took to document care left nurses feeling “very frustrated, it takes a very long time, nurses leave late all the time because you see them just sitting there finishing their charting” (participant 2, line 529-530). Participant 5 was annoyed because she felt the documentation system made her change her nursing practice, “I think that [electronic documentation] has changed my nursing to a certain extent, increased the frustration in my

practice” (line 419). Her frustrations were high because she was unable to document the way she wanted to, “I know what I want to do [chart] and I am unable to do it” (participant 5, line 419-420).

Having to access up to 4 different patient charts to “cobble together” (participant 5, line 1185) the information needed to provide appropriate patient care was irritating for nurses, “I honestly have no idea how you come to that kind of decision to buy completely different software for all the different areas of the hospital, that can’t communicate with each other” (participant 10, line 508-510). Nurses were frustrated with leadership for buying technologies that were so difficult to manipulate, “why isn’t it [technology] easier to use? Don’t they [leadership] get how we work?” (participant 4, line 181-210). Participant 9 echoed similar dissent with the purchasing of multiple technologies:

But they [leadership] give you these tools, these electronic tools. They give them to you and they insist that you use them. We have this great new monitor, this great new saturation monitor, this great new warmer, this great new bilirubin bed. Everything is great and new, latest and greatest, greatest new pump, great new pharmacy machine, great new, great new, oh, and “it will make your life so much easier, you’ll love it, it’ll be faster, it’ll be better”. And nurses are so busy and so rushed, anything that’s going to make their life faster and better they’ll fall for it, “ok, yes, let’s try that because it will be faster and better”. Except it isn’t faster, except it isn’t better, except it isn’t helping me (line 1006-1014).

Participants were perplexed by the purchasing of multiple technologies, when the topmost request by nurses for many years was simply more nurses, not more equipment, “I can remember over and over and over again we, need more nurses, we need more nurses” (participant 8, line 665), “more staff need to be on [per shift], you need more nurses” (participant 11, line 424). Nurses’ requests were met with responses such as, “you don’t need more nurses, you don’t need more bodies and hands’, no, we’ll just give you this [multiple technologies]

instead” (participant 9, line 1044). Nurses quickly realized after witnessing ongoing funding allocations to multiple technological changes instead of additional nursing resources, that getting more nurses “that’s not going to be the result, it’s not our reality” (participant 8, line 666). Nurses were frustrated that leadership perceived technology to be more reliable than nurses, “it’s frustrating, the fact that a number on a machine is more trustworthy than we [nurses] are considered to be, or more observant” (participant 5, line 749-750). This angered participant 5 because, on numerous occasions, her assessments of patients’ health status deterioration were not weighed as reliable as technological findings by other important members of the interdisciplinary team:

When you’re only looking at screens, you’re only getting a fraction of the picture, I guarantee you you’re not getting the most important part [of the assessment]. That’s what’s frustrating me, it is (participant 5, line 760-761).

Technological changes created physical and metaphorical separation between nurses and patients, which compromised provision of a culture of care. One participant described this distance as follows: “you just feel like you’re climbing a mountain of obstructions between you and your patient, that you want to deliver care to” (participant 5, line 1060-1062). These obstructions diverted nurses attention away from patients, “you’re babysitting a pump; you’re babysitting this bloody computer on wheels, that you want to kick” (participant 5, line 1063).

### **Feeling Distrustful**

There’s no trust at all left for leadership (participant 10, line 383).

Anger was highly evident in participants’ discussions of feeling distrustful. Participants experienced eroding relationships with hospital leadership over the years, most often noted to be a result of the manner in which change initiatives were implemented. Many participants argued this erosion of relationships contributed to a significant lack of trust in the organization. Participant 12 identified that her lack of trust in the HCOs leadership, which was combined with a healthy sense of cynicism, was directly linked to leadership’s ongoing lack of transparency,

lack of nursing engagement in the change process, and ineffective leadership communication with frontline staff. Participants with longevity at the institution were quick to note that they had observed a pattern in management behavior over the years, “you see it time and time again...they don’t involve the frontline workers from the get go...that’s what fosters the lack of trust” (participant 4, line 204-206). This pattern including having “been lied to so many times for years” (participant 10, line 374) and frequently having had “the whole story” (participant 10, line 377) about impending change initiatives withheld until after the changes had been implemented.

Mistrust is a general sense of unease toward someone or something that can be an outgrowth of continued distrust. Participants’ described erosion of trust. For example, participant 10 perceived management rhetoric associated with change initiatives as “kind of rigged one way or the other to justify where they’re coming from” (line 377), while participant 4 speculated that “they [leadership] aren’t telling me everything. There must be a hidden agenda” (line 418), which left her questioning, “why aren’t they just being upfront?” (line 421). Participant 4 stated that management had “pulled the rug” (line 119) from under her during a particular change years ago. Consequently, she felt “uncertain and scared” (line 119) for herself and her colleagues whenever subsequent change initiatives were announced, “well if they did that last time what are they going to do this time?” (participant 4, line 118). Similarly, participants became highly cynical about managements’ “underlying message” (participant 4, line 501) for any and all change initiatives, which was, “absolutely always to provide better patient care, safer patient care” (participant 4, line 502). But as participant 4 continued to articulate her feelings about change initiatives, she noted that she mistrusted managements’ discourse because “there’s always a component of ‘it should be faster, do more with less’” (line 502-503), even if it wasn’t stated, and really “that was the key message” (line 503). As participant 10 noted, when leadership spent “7 years eroding trust...it’s going to take years of continually proving yourself to be trustworthy, transparent, and open” (line 405-407) to rebuild it. A change in leadership personnel was not sufficient to convince nurses to “just trust us [leadership]...because we are

different now” (participant 10, line 385). Furthermore, participants recognized that their feelings of distrust and mistrust as a consequence of past experiences with rapid and continuous change “will always impact their ability to deal with future change and that’s really important, because everyone always remember if something went poorly” (participant 4, line 407-408).

One experienced nurse pondered whether some of the implemented changes, or perhaps the rate at which they were implemented, was a strategic way to rid the hospital of experienced nurses. This jaded perception stemmed from years of lost trust in leadership, “There was a lot of uncertainty again, several of us felt in our unit in particular, ‘was this just a way to get rid of more senior nurses?’” (Participant 4, line 336). This mistrust was “based again on loss of trust from previous changes that some of us had been involved with, we kind of got the sense, is this a way they’re going to try and get rid of us?” (participant 4, line 340-342). Intentional or not, the attrition rate of experienced nurses rose following rapid implementation of multiple changes.

Lean implementation, specifically, fostered mistrust amongst nurses because, Lean was providing leadership “a 2 for 1 deal, they’re [nurses] doing their own work plus these other things that management didn’t have to worry about paying them to do” (participant 13, line 58-60). This was described as “a sneaky way to get them [nurses] to do more work for the hospital without having to be paid for that work” (participant 13, line 61-62). Others speculated that Lean was only implemented to “make them [leadership] look good...really it [Lean] was just more administrative and corporate changes being added to piles of changes” (participant 14, line 4014-409).

Another change that “made me a bit suspicious” (participant 13, line 590) was an abrupt modification to the medication administration policy that coincided with the implementation of the medication cabinets. Previous policy stated that nurses were allotted 30 minutes prior to and following the scheduled medication administration time to safely administer a medication without the need to complete an incident report. Amended hospital policy stated nurses were now

allotted 60 minutes prior to and following scheduled medication administration times to safely administer medication. The abruptness and timing of the change “made you feel like, ‘where is that [practice] change coming from? Who’s making that decision?’” (participant 13, line 574). Participant 13 speculated that this amendment was “based solely on the equipment, because we don’t have a huge amount of them, we only have one per unit” (line 588), which as previously described, created delays in medication administration.

Participants recalled two new hospital initiatives that undermined parent’s trust in nurses which, in turn, fostered nurses’ mistrust and anger in leadership for implementing the new initiatives. The first initiative saw “volunteers, well meaning I’m sure” (participant 5, line 338), coming into patient rooms to “tell every parent that when a nurse comes to your patient with medication you need to ask if this is the right medication at the right time” (participant 5, line 339-340). Participant 5 believed doing this “was the worst thing in the world you can do to our patient population” (line 345-346), because it “gave them a sense that we [nurses] are not to be trusted with their children, and that if they [parents] aren’t at the bedside that patient will not be delivered quality, excellent care” (line 346-347). The second initiative was parents being given “little popsicle sticks that said ‘wash your hands’” (participant 5, line 327), which were to be “waved in front of nurses every time they came in [the patient room]” (participant 5, line 348). These messages to parents “implied that nurses were not be trusted, and that was so damaging” (participant 5, line 359-360).

Another way in which mistrust manifested was the apparent push to deskill nurses, with participant 11 speculating, “the whole institution is working to deskill nurses” (line 667). Nurses speculated that leadership adopted “the culture that machines can replace humans” (participant 9, line 1001), noting that within the workplace there was “such a push to get rid of that nurse because you can replace that with a machine and a monitor” (participant 9, line 1015-1016). Other participants observed that there are “less people processing things and more machines [doing the work of nurses]” (participant 4, line 496). Participants felt this way because it seemed

“there’s always this layer of technology that is supposed to be better than us, between us and the patient” (participant 5, line 731-732), which led nurses to believe that “the machine is more important than a person is, the ultimate message that gets dribbled down [from leadership]” (participant 1300).

The final example that fostered mistrust amongst nurses was the hospital being awarded a top-ranking award that saw the institution “voted the best place to work [in the province]” (participant 6, line 283). The associated press coverage and signage throughout the hospital advertising the award was described as “propaganda” (participant 8, line 489) that made participant 6 “sick when I hear that” (line 282). Nurses questioned, “who voted that?” (participant 3, line 488) as “nurses at this hospital make up the biggest population of employees” (participant 3, line), “I don’t know who’s doing the voting because it’s nobody I know” (participant 6, line 285). Others questioned, “did [leadership] they vote on our behalf?”, while participant 8 speculated that it was “a stuffed ballot” (line 488). The aforementioned signage around the hospital “makes you feel like you should be grateful for what you have...that’s what they’re [leadership] saying to us, ‘be grateful for what you have’” (participant 8, line 494). This aggravated nurses because “the image that is portrayed [within the hospital and in the city]...is such bullshit” (participant 6, line 285-287), “this is not the greatest place on earth” (participant 8, line 495). Participant 6 suggested, “if only the public knew...I would say to the public that upper management doesn’t care about any of the nurses or any of the allied staff” (line 287-309).

### **Feeling Distressed**

Participants expressed distress in relation to patients, families, their colleagues and the future of nursing. One participant was sad that parents recognized a change in staff morale over time, “It’s sad. That is the last thing you want to portray to parents. You want to portray that everything is good...but you feel so different, and it’s sad to hear they can see that” (participant 6, line 280-284). Participants felt distressed when they were unable to fulfill their moral commitments to enacting a culture of care:

I don't have time [to provide the best possible care] and that's heartbreaking. You give them meds but then you have to walk away and just leave them...because you don't have the time to sit with them and care for them. It's not right (participant 7, line 303-307).

Other participants felt "distressed" that they were now unable to support families due to time constraints. Participant 13 recalled an example years ago when she was able to give a patient's mother 4 hours of nursing respite for her medically complex child. The respite time enabled the mother to "go for a shower...go for a break...go spend some time outside" (participant 13, line 787-795). Participant 13 lamented that "there would be no way we could give that support to families now" (participant 13, line 798), which "distresses me, because you're not just taking care of the patient, you're taking care of the family and you're not able to provide that respite care" (line 800-801). Experiences like this one made nurses "feel like you're letting them [patients and families] down. You feel like you're not doing your job to the best of your ability" (participant 13, line 243-244). The current reality was that nurses were only able to deliver this level of care when they were overstaffed, "the only time you see a nurse give holistic care to a family, for me to go into a room and sit with a family and teach them, it would be when we are overstaffed...it's very rare, it's sad to say, but we don't [have the time]" (participant 2, line 130-136). Participant 14 noted that only when unit staffing was "fluffy" was she able to provide holistic nursing care. Participant 14 described "fluffy" as:

Being able to do all your work not feel stressed about it, having your charting done on time, which never happens, you always retro chart because you're always scrambling to get everything done. And then having time to play with the patients or provide a bed bath or something and take the time to give your patient a hair wash (line 715-719).

Participant 14 argued that "fluffy" staffing levels were actually "the capacity at which we should work if we really wanted to give excellent patient care" (line 724). Having adequate time to engage in activities that reflect a culture of care, for example, "do the right assessments, to

do them properly, to find out what needs to be done and do it accordingly” (participant 9, line 1427) were “really satisfying, really fulfilling” (participant 9, line 1428) elements of nurses work.

Worry was a significant element of feeling distressed. Participants worried about protecting their nursing licenses in light of their working environment. They described their fear that understaffing, inappropriate staffing, and increased work loads associated with managing multiple change initiatives compromised their ability to deliver safe care in ways demanded by their licensing body. Participant 9 recalled being told to “cut corners” to achieve efficiency goals of the department, “these are peoples licenses on the lines, this is their scope of practice [potentially being compromised]” (line 396), arguing that, “you don’t cut corners when it comes to patient care” (line 397). For participant 11, ongoing staffing shortages made it very difficult to follow policies for the verification of narcotic administration, which required two RNs, “I’ve looked out from the med room and there’s crickets down the hall, like ‘hello, is anybody there?’” (line 444). This participant questioned the safety of such staffing levels:

How can you practice safely if there’s no one there to check your meds? That’s a requirement, we have to double check specific meds, our license is on the line. We’re all going against our practice standards [when we can’t find a second nurse to co-sign medications] (line 445-447).

Increased workloads worried participant 14, “you feel unsafe [with assigned workloads]... it’s my nursing license on the line, I’m going to forget something, I’m going to make a mistake” (line 95-97). Participants recognized that “[sometimes] you have to stand up and say, ‘no, this is not safe [staffing ratios, patient acuity exceeding nurses skillset] I’m not doing this because my license is too important to me’” (participant 1, line 743-744). They also admitted that at times it was hard to enact this belief system because of the pressures they felt to maintain and even reduce hospital costs associated with staffing.

Floating distressed nurses because of their associated worry. Floating to an unfamiliar unit made participants feel incompetent, and knowing what they didn’t know increased their

worry because they knew competence prevents mistakes. Participants' worry and anxiety regarding floating stemmed from being unable to provide safe patient care, a significant element of a culture of care. Floating to units that were not their specialty area "was terrifying" (participant 5, line 457), "anytime I've floated I've been absolutely terrified" (participant 6, line 199). Participant 6 noted that some nurses found floating so distressing they left the organization: "I do have former colleagues that have left [the hospital] for the floating issue" (line 214). When nurses floated, "the anxiety level shoots through the roof" (participant 5, line 461). Nurses felt incompetent when floating, "I don't know what I'm doing" (participant 1, line 583), "I feel dumb" (participant 6, line 212), nurses felt "like you're a student all over again" (participant 1, line 583). Participant 1 noted that "if you don't have supportive staff that makes it [floating] even harder to deal with" (line 584). This was an increasing reality as time constraints and resource depletion continued to negatively impact the capacity and will of experienced nurses to offer mentorship and support.

Nurses were further distressed by the impact floating had on their colleagues, noting that even though the charge nurse role had become more administrative, "the poor charge nurse has to make sure that [floating] nurse is not drowning" (participant 1, line 601), which is "not fair for the person being floated who's been thrown in there at the deep end, but it's also not fair for the existing staff because they've got to meter out so much extra support" (participant 1, line 601-605).

Participants were worried about inexperienced nurses and the future of nursing should work conditions remain the same. Current work conditions created environments where experienced nurses felt they were "putting young nurses into a shit situation...I've got junior staff doing things I know is over their head but we don't have anyone else [to do those things]" (participant 9, line 1743-1790). Nurses believed these situations left new nurses "treading, they're barely keeping their head above water and I'm scared for them" (participant 8, line 287). This fear came from the recognition that inexperienced nurses were not given the opportunity to

learn in a safe and supportive environment. They recognized that “there’s a learning process [for inexperienced nurses], there’s nothing wrong with it, but you have to provide people with the opportunity to learn in a safe environment and when you don’t patients suffer” (participant 11, line 420-422). The inability to learn in a safe and supportive environment was problematic because “they [inexperienced nurses] don’t learn good quality nursing” (participant 8, line 289). Subsequently participants felt that the repercussions negatively impacted inexperienced nurses and patients.

Experienced nurses worried about what was to come after their departure from the organization, “I’m part of the tsunami that’s going to disappear off the cliff in 5 years [retirement] and there better be people who are going to step up to the bar and keep that quality of care, and I’m not too sure [there are]” (participant 5, line 38-39). Their anxiety stemmed from the impact of multiple change initiatives, which included: deskilling practices, increased reliance on technology, “this unbelievable surge in technology and digitization” (participant 5, line 534), a growing belief that technology was more reliable than nurses, all of which fostered an ongoing sense of devaluing in the workplace. Feeling devalued “doesn’t inspire the need to know more, to learn more, to become better at what you do because, well, it doesn’t matter because they don’t [leadership] care” (participant 14, line 455-456). Experienced nurses were concerned that demotivation to know more as a result of deskilling and reliance on technology would create situations where “one day the systems [medication cabinets, dilution calculators, intravenous pumps] will just shut down and people aren’t going to know what to do. We’re going to have a major downtime and people won’t know how to calculate, mix or dilute medications” (participant 11, line 660-663).

Nurses’ apprehension also stemmed from the perceived challenges of upholding professional values of beneficence (to do good) and non-maleficence (to do no harm) that guide their practice. Participants reflected that many of the change initiatives implemented created a new normal in their work environment that made it much more difficult to consistently do good

and avoid harm to patients. Nurses frequently questioned, “Did I do everything I was supposed to do?” (participant 14, line 677) when, in their current work environment, they felt “you’re being pushed with crazy patient loads and you’re run off your feet” (participant 14, line 667). This worry drove nurses to “leave your cell phone number to the next nurse, so they can text me if I forgot anything, because the day was a blur” (participant 14, line 679-680).

Participants discussed how the older generation of nurses believed this new normal altered nursing identity. This led participant 5 to suspect that “I don’t think it’s [nursing] feeding our younger generations of nurses” (line 447). The older generation of nurses had experienced a time in their career where they “knew it felt really good to care” (participant 5, line 546); when HCOs were driven by a culture of care. Now, senior nurses worried that the younger generation of nurses, who have started their careers in a culture of service, “I don’t know if they know what they’re missing” (participant 5, line 433). Knowing and being able to enact elements of care, for example, “basic care, comforting the child...that’s what they’re missing, this young generation is missing” (participant 2, line 371-372). Elements of care appeared to be the “something there in the slip string that we’re losing at a rate of NOS [nitrous oxide]” (line 537) that participant 5 referenced in her reflections on the changing identity of nursing. The participant used NOS, in this content to explain its properties as an accelerant, and to exemplify the rate at which nursing was changing. Participants worried that the “younger generation of nurse” (participant 5, line 490) would not be inspired to seek knowledge required to provide exceptional patient care in the same way that previous generations of nurses did, “We were all smart enough to know how stupid we were when we started out 40 years ago, not sure that’s the case anymore” (participant 5, line 518-519). Participants worried that the loss of nurses “being smart enough to know how stupid we were” would maintain a culture of “good enough”.

Manifestations of participants’ distress were multiple and reached far beyond nurses work hours. At the commencement of a shift, for example, nurses “would see each other at shift change with tears in our eyes” (participant 9, line 1608). For participant 11, nursing was very

difficult when she felt pressured from leadership to admit patients without the proper staffing. Her distress manifested because she had to admit patients without what she deemed an adequate staffing level:

I hate it [current work environment], I've left in tears...I find it [work] incredibly stressful...more than once I've broken down in the report room where you've barely held on all night long...going "oh my God, if something happens tonight, we're in trouble" (participant 11, line 332-347).

Participants continued to experience distress once they were home from work, with one participant noting she was unable to meaningfully connect with her children for a certain period of time following her shifts. This nurse required that immediate time to herself to decompress, "I would get home and it was like, 'ok kids, give me half an hour by myself'" (participant 2, line 761). Time to decompress allowed participant 2 to "unwind and clear my head because those poor kids are talking to me and I'm like, 'uhmm hum, uhmm hum, uhmm hum', nothing would register because it [work] was too much, just stressful" (line 762-763). Participant 8 recalled similar experiences, "I used to get home at 8:30 at night, I didn't have the wherewithal, I didn't have a focus on my children" (line 804-805). Many nurses "curled in on their own" (participant 9, line 721) and avoided contact with others immediately following a shift, "don't ask me to go out, I can't possibly socialize, I can't possibly be polite to one more person, I can't do it" (participant 9, line 744).

Some participants found themselves unable to sleep at night, "coming home at night and just not sleeping because in my head there's 150 things I didn't do, that didn't get done, that I forgot about" (participant 9, line 306-307). The "things" left undone that distressed nurses were care activities, for example, "I promised that mom a blanket, I promised I'd get her formula, I promised her I'd get juice. I didn't even bring that kid a popsicle" (participant 9, line 308-310). Not doing these things was distressing because, to her, they are "the simple human things that you should do for your patient when you're taking of the them" (participant 9, line 311), but she

was unable because “the minute I think I can do that, 17 things interrupt me...it’s awful” (participant 9, line 312-314).

Another participant found herself phoning the hospital unit she worked on hours after completing her shift, because “I was worried about staffing, I was worried about the floor” (participant 8, line 805). This participant would call the unit to ensure her colleagues were managing, “I’d wake up and call, ‘How are you guys doing? Have you been to breaks? Do you want me to see if someone can come [from another unit]?’” (line 807-808). This participant questioned her actions, “why am I, at midnight, worried about it?” (line 814), but acknowledged it was because “I have the face it [the unit] in the morning” (line 815).

The distress nurses experienced at work in response to rapid and continuous change implementation impacted their coping mechanisms: “if implementing changes are [sic] making life really hard at work then that’s going to impact your home life, there’s no getting away from it” (participant 1, line 1517-1518). Participant 1 recalled “sitting at home in tears because you’re so overwhelmed with all the change that’s been implemented...it’s overwhelming when you come home, you’re not dealing with it [changes] well” (line 1520-1521). This impacted relationships at home: “so you winch at your hubby and he’s not going to be happy about that” (line 1522). Stress at work exacerbated existing stressors at home: “if there’s a stressor at home people are not coping with having the stress of work with the stress at home” (participant 9, line 647-648). In situations like “people in the process of divorce, a sick kid, or a death [in the family]...if something tips you over the edge at home as well, people aren’t coping well [with change]” (participant 9, line 649-652). To cope with this distress, some nurses turned to depressant substances such as Gravol, Benadryl or wine, “I mean how many nurses do you see that have to take Gravol before they go to bed after a shift? They have to take Benadryl or Gravol to try and sleep” (participant 2, line 757-758). Others turned to wine, “A lot of nurses say ‘oh yah, I’m going to have a glass of wine’, why? Because it relaxes them” (participant 2, line 759-760).

Participant 9 reiterated this sentiment, “now I go home, put my feet up, put a cat on my lap and drink a glass of wine” (participant 9, line 744).

### **Emergence of Change Fatigue**

Two participants noted change fatigue. Participant 5 stated that “certainly we did have some change fatigue after all of these huge changes that were imposed on us” (line 995-995), while participant 8 expressed that “there’s fatigue, there’s change fatigue for sure. I think we’re tired” (line 702). For participant 8, change fatigue meant, “‘Oh no, not another thing’. I saw that over the years... ‘oh god, one more thing’. Change, it’s constant, it’s one thing after another, I think we’re just tired” (line 724-730). Participants recounted, “years and years of change for all staff, it just hasn’t stopped” (participant 8, line, 7) which left nurses feeling that they “just haven’t gotten our feet back underneath us” (participant 8, line 8). Participants felt the changes were “overwhelming...you’re expected to know about all this stuff [ongoing changes] and I can’t keep up” (participant 1, line 23-28), participant 9 lamented that “I can’t stay on top of all of this [change]” (line 1597). Participants noted, “it can be difficult to master all of the changes that are expected of you” (participant 1, line 29). In addition, the work environment was “still not fun” (participant 9, line 826) following years of rapid and continuous change, which was a manifestation of the ongoing impact on staff, “everyone is still a bit tired, everybody is a bit done” (participant 9, line 828).

Many participants recalled experiences of exhaustion, “It was just really tiring, it was just one thing [change] after another, it just tired people out” (participant 1, line 464-465). Staff “really felt tired” (participant 4, line 244), noting “there’s only so much you can absorb, there’s only so much you can learn...there’s a level at which sometimes it’s overwhelming because you’re expected to know so much” (participant 1, line 694-698). These repeated feelings of exhaustion altered nurses perceptions about change in their workplace, “we have seen a lot of change, therefore our perspectives on change is very different, because you get tired of it” (participant 1, line 93). Nurses were now skeptical of change, questioning, “do we really have to

do this one [change] now?" (participant 1, line 470-473), making remarks such as, "oh my god, some more [change], again" (participant 1, line 454) and, "oh here we go again, another change that's not going to work" (participant 4, line 210). Participant 9 suggested that, "people aren't trying as hard, everybody is a little bit exhausted, a little bit done" (line 797). Participants were exhausted in part because of the stress that accompanied change, "all of the change was really stressful for staff" (participant 4, line 244) because "if you're working on a unit and those changes are coming one after the other and you've got to deal with it on a daily basis it's hard, it feels arduous" (participant 1, line 447-457). Participants were not only exhausted from the impact of the changes, but also how the change process repeatedly unfolded, "they didn't want the changes because they felt like it was being put on them" (participant 1, line 471). Nurses did not perceive change as a collaborative activity between leadership and frontline staff.

Participant 8 linked the experience of change fatigue with the loss of what she called "lulls", periods of time that facilitated a recovery process, either after change, or after a very stressful period at work. These "lulls" included periods of time such as summer and Christmas. "Lulls" were times when the hospital seemed less busy and the overall acuity of patients was lower than usual. Participant 8 described the loss of "lulls" in relation to increasing patient acuity:

It would be nice just to have a lull for a while. We don't get our summer lull like we use to, and that's a huge change we haven't even recognized. The illnesses that are out there, the acuteness of them [patients] is so much more...you've seen the lulls and you've seen the increase [in acuity]. We talk about respiratory season versus non, it's all year now, whereas in the summer we used to practically empty out. Now you won't ever get that. The acuity of the patients getting admitted, half the patients that used to come up to the floor don't come up anymore, so the ones that do come up are really sick (line 701-716).

Nurses experienced change initiatives within a complex system that took into account patient acuity, changing patient populations and increasingly complex demands. Participants

were unable to manage rapid and continuous change when there were no longer periods of “lulls” or even that “bit of downtime to have a giggle” (participant 11, line 1020). These “lulls” and periods of “downtime” previously allowed nurses to depressurize and recharge in preparation for the busier peak seasons associated with certain diseases (e.g., respiratory season), which accompanied high stress work environments heavier workloads. Lulls provided nurses the time they needed to adapt to changes, as more time could be spent learning new workflow processes and troubleshooting new technologies. Those “lull” periods of time were what “keep us all sane” (participant 11, 1020).

Without “lulls”, or recovery time, rapid and continuous organizational change lead to the emergence of four characteristic behaviors associated with change fatigue. They included: apathy, burnout, feeling voiceless and powerless.

### **Apathy**

As time progressed, some nurses became numb to rapid and continuous change: “You become numb to the changes that are occurring at the institution, you’re like ‘oh, well, it’s just another change, let’s just keep going because we have to get our jobs done’” (participant 13, line 398-400). One participant described her experiences of numbness, suggesting that nurses were becoming robot-like in response to rapid and continuous organizational change:

It’s like you’ve become a robot, and you’ve become numb to the fact that you should question the changes, and you’re not encouraged to question the changes. You’re just told what’s going to happen, and to get on with it and keep going. I find nurses are just becoming numb (participant 13, line 402-406).

Other nurses felt the need to “disconnect from your work environment in the sense that there’s so much happening, people stopped caring... ‘whatever’, rolled their eyes, ‘oh, another change’” (participant 14, line 413-416). Participant 11 provided the rationale for this behavior, “To be honest, there’s been so many changes in the hospital that if you get excited or frustrated over every single one I think it drives you to distraction” (line 162-162).

Some participants became apathetic to consequences of rapid and continuous change, for example, repeatedly missing their breaks. “We often get told, ‘Today, no breaks guys’...and we just take it” (participant 2, line 781). This participant was unable to articulate why this had become the norm, “I don’t know why, we just take it” (participant 2, line 782).

### **Burnout**

Participants made multiple references to burn out in relation to rapid and continuous change. Burnout was both the result of ongoing change implementation and accompanying increased workloads, as additional resources to support staff often did not accompany changes:

It’s physically not possible to do more with less, everyone is working flat out...I just don’t see how we can do more with the little that they’ve [leadership] give us, as a hospital we are struggling...every department is stressed; every single department is under pressure (participant 9, line 1652-1678).

Attempts to keep up with multiple changes under such pressure fostered burnout, “we keep trying [to keep up], and it’s burning everybody out. There’s already a lot of people crispy around the edges” (participant 9, line 1663-1664). The volume of change resulted in nurses consistently “being overworked” (participant 9, line 178; participant 2, line 177), which led them to “get burnt out” (participant 2, line 177). Consistently being overworked and subsequent burnout contributed to units being unable to function: “then the unit can’t function anymore” (participant 2, line 177).

Burnout was intrinsically related to ongoing and prolonged self-sacrifice. “We [nurses] take it upon ourselves to do the extra mile and constantly do the extra mile and then we burn out. We have nothing left” (participant 12, line 312). The “extra mile” consisted of care activities that a culture of service did not often allot time for, but that nurses still felt morally committed to provide. Nurses did not have the energy left to care for themselves, which contributed to burnout: “you need to give so much [of yourself] at work, and then when you feel like you need a

bit more energy for yourself, there's nothing left, there's not enough to cover all your needs" (participant 14, line 70-73).

Participants described multiple examples of self-sacrifice that included both activities during and exceeding beyond paid work hours. Increased demands on nurses as a result of change initiatives saw them routinely missing breaks, or staying late to complete care activities: "you're constantly giving that half hour or hour every time you come in, you're missing breaks as well...because there is not enough time in a 12 hour shift to do everything you want to" (participant 5, line 1140-1150). Nurses who felt unable to meet the moral imperative of providing a culture of care, compensated by sacrificing their self-care, "to be with patients we sacrifice" (participant 12, line 241). Nurses felt that to meet care needs of patients they must "take away your time, you start taking away your break time and you start taking away time to drink, time to go to the washroom, time to keep yourself healthy" (participant 12, line 239-241). Nurses also sacrificed some of their time away from work, for example, to catch up on emails "I rarely check it [email] at work. I check it at home. I don't have the time to do it at work, I feel like I have other things to be doing" (participant 11, line 204-206). Other participants also checked email at home, "I check my emails at home, otherwise I miss stuff [important updates]" (participant 1, line 656), as updates were primarily communicated via email. Participant 7 checked emails at home but resented having to do so, "honestly I don't have time to check my emails when I'm at work. I usually do it at home, I actually hate checking my emails at home because I don't want to think about work when I'm at home" (line 195-197). Carrying out unpaid work activities during non-work hours contributed to "resentment" (participant 9, line 1258), specifically the "resentment of the organization" (participant 13, line 254) nurses described feeling towards their workplace. The resentment participant 13 spoke of was a result of the ways in which she felt nurses must sacrifice their own well being to ensure patient care was not compromised:

The fact that you don't look after yourself because you're so worried about taking care of your patients and giving them the best thing that they need that your own self gets left

behind. It's fine one shift or two shifts but when you keep doing this over and over again it leads to burnout, resentment of the organization, resentment of your peers. You just are unhappy and you feel anxious and you don't feel like you want to come to work, it's those kinds of negative feelings that occur (line 251-256).

When asked why nurses continued to engage in self-sacrificial, detrimental acts, participant 13 replied, "Inherently nurses are caring people and that's why we keep doing what we're doing [self-sacrifice]" (line 297). Participant 9 echoed this sentiment, "we let this shit happen because we're nurturers and we're carers and we're still going to nurture and we're still going to care and we're still going to do our best for our patients because we always do" (line 1342-1344).

Participant 6 cited burnout from organizational change as the reason experienced staff no longer volunteered to mentor inexperienced staff:

We moved to the new unit, we got the electronic charting, we got new [IV] pumps, new feeding pumps...it was a lot, and it was a lot for people trying to teach [inexperienced nurses]...to be worrying about all that stuff and trying to teach someone I think it's difficult. It's very hard now to find a preceptor on our unit, they are few and far between...they're burnt out (line 421-440).

In addition, they speculated that burnout as a result of rapid and continuous change was creating a work environment where "I feel like we're edging to the point where there will be some nurses who just say it's not worth it anymore" (participant 9, line 1278), noting that "the whole hospital has coped as much as it can" (line 1807-1809). For participant 13, ongoing feelings of burnout "definitely make you feel like, 'why did I become a nurse?'" (line 264). Participant 13 began to "question a lot of things about why you are doing this [continuing to nurse]...there comes a time when you start questioning 'is this what I want to do for the rest of my life?'" (line 265-269). Considering work conditions associated with rapid and continuous change, participant 9 reflected, "if I was a young nurse starting off, I wouldn't stay at this

hospital" (line 1665). Other participants' echoed similar sentiment, "when it [lack of support through changes] just keeps happening over and over again, it wears you down" (participant 13, line 273). This participant noted that "there's a certain limit to people...there's only so much you can take, it's [ongoing lack of support] a form of abuse, you can only take it, take it, take it for so long" (participant 13, line 274-275). Participant 13 was edged to "the point" at which participant 9 suggested "there will be some nurses who just say it's not worth it anymore":

There comes a day when you say, "no, I'm not going to take it anymore". You have to make a choice and make a change. You either keep doing what you're doing, even though there's not going to be that help or support from the organization, or you say, "I'm leaving this", or, "I'm moving on and I'm going to do something else" (participant 13, line 274-279)

The available changes for participant 13 included "you change your job, change your position, leave the organization, or you just leave the profession altogether" (line 279-280).

### **Powerless and Voiceless**

Participants felt both powerless and disempowered in their practice as a result of rapid and continuous organizational change. Participants felt powerless in the decision-making process associated with each change initiative: "you felt powerless because they weren't getting the nurses opinions or including them in the decision-making" (participant 14, line 378-379). For nurses this meant, "you don't feel powerful when you're really the frontline people that are using these things all the time and they [leadership] don't care to ask you" (participant 14, line 214). The lack of involvement in decision-making "took away any kind of power, power in a sense of being part of...we're the ones having to work with it [changes]" (participant 8, line 588-590). Participant 9 felt "pretty powerless" (line 1401) when "there's too much very top-heavy decision-making going on and very little bottom up control" (line 1396-1397). Participants who felt powerless believed, "we have been ignored [in the decision making process] because we [nurses] are low down on the totem pole" (participant 5, line 239).

Participants felt disempowered due to the organizational belief that a “nurse is a nurse is a nurse” and deskilling practices, changes that diminished the value of nursing knowledge, “that [not recognizing nursing knowledge] doesn’t empower nurses and doesn’t inspire the need to know more, to learn more, to become better at what you do” (participant 14, line 454). Nurses suggested their knowledge “doesn’t matter, because they [leadership] don’t care [about nursing knowledge]” (participant 14, line 455). In these disempowered circumstances nurses suggested you “aren’t in control of your own career path, you’re not even in control of the trajectory of your job from week to week [in reference to floating practices]” (participant 9, line 1398-1399).

As previously noted, increasing floating practices were directly linked to the growing premise that “nurse is a nurse is nurse”. This belief made nurses feel powerless: “a nurse is a nurse is a nurse” belief takes away nurses power and it takes away her skillset by saying, ‘oh, you can go there’” (participant 9, line 1465). Consequently, the frequency of floating practices made nurses feel powerless often, “you never know where you’re going to be next day” (participant 9, line 1400). When floating, participant 9 felt that she had “no power there. I am not a powerful person, that’s not my skillset. Within my skillset I have the power to manage things very well, but take me away from my skillset, my scope of practice where I’m a specialist and you put me somewhere else, you are diminishing my power” (line 1471-1473).

Standardized practices worked to “shrink the little box in which you [nurses] have to practice in” (participant 14, line 419-420), which was said to “take so much power away from nurses” (participant 14, line 423). Deskilling practices were said to “take so much independence, critical thinking and power away from nurses” (participant 14, line 429), which made participant 14 feel “like nurses are not being empowered to work to their full capacity” (line 429). Participants who experienced a loss of power “don’t feel independent, you don’t feel empowered, you don’t feel recognized and your knowledge isn’t recognized” (participant 14, line 443-444).

Feeling powerless was perceived as “such a shame” (participant 9, line 1503) in nursing because “power in the profession [of nursing] is important” (participant 9, line 1503). Participant 9 offered insight into what power and empowerment looked like in nursing:

[Having] power over your own skills, your own talent, how to use your skills and talents to the very best of your abilities. When you’re empowered to do that, you’ve got the right training, you’ve got the right guidance, you’ve got the right mentors, it’s wonderful (line 1454-1457).

Participant 9 further elaborated that power was important to nurses because “when you have power...it’s a really satisfying, fulfilling thing” (participant 9, line 1406-1427). Moreover, she noted that “power is influence” (line 1475). Influence, for participant 9, meant “influencing the direction of the department, the direction of policies, procedures” (line 1477), which was different than “sitting on some hospital committee” (line 1478). As participant 2 highlighted, being a member of a hospital committee did not necessarily result in their ability to make meaningful contributions to change discourse if they were not supported in attending the meetings. Nurses desired empowerment, but they recognized that a philosophy embracing empowerment could create tension between a culture of care and a culture of service:

Lets empower nurses to do what they can do and do it well even if that means more time, more training, whatever. But that all costs money and it all takes an investment” (participant 9, line 1443-1444).

Some participants attributed their feelings of powerlessness to the gendered nature of the nursing profession. They suggested that “women are passive and it’s a mostly women dominated field” (participant 9, line 1339) and as a result changes were passively accepted: “we let this shit happen because we’re nurturers and we’re carers...there’s this kind of defeatist acceptance of it [powerlessness by default of gender]” (participant 9, line 1340-1342). Nurses proposed that, in comparison, “if men weren’t the minority [in nursing]...some of this stuff wouldn’t be implemented at all because the guys would have just stood up and said, ‘no that’s

not happening” (participant 1, line 1472-1474). However, because “we’re women, we’ve always been dominated” (participant 9, line 1351), nurses appeared seemingly powerless over the change process.

Nurses experienced a loss of power that was compounded because “no one is speaking up [about the negative impacts of change] and that diminishes our power, it diminishes our influence, it diminishes us” (participant 9, line 1502-1503). Nurses felt powerless to speak up because “there’s a lot of fear in people” (participant 9, line 1337), so nurses “are just shutting their mouths” (participant 9, line 1377), noting that “no one is powerful enough to say ‘I don’t want this [change], this is too much, I’m overwhelmed” (line 1488-1489). For participant 9, fear had negative implications for nursing, “everyone is afraid to speak up and that diminishes our power” (line 1499-1500).

Nurses feared they might lose their jobs if they spoke up, “everyone is afraid for their jobs” (participant 9, line 1498), equating speaking up to “putting a target on your back” (participant 7, line 254) and placing themselves “on the chopping block” (participant 7, line, 223). Conversely nurses feared leaving their place of employment, despite the emotional repercussions of remaining. Moving to another hospital meant they would no longer be able to work in the pediatric specialty as there is no other geographically accessible pediatric hospital. Nurses thus felt powerless over their employment because the hospital’s leadership had, according to participant 8, “captured us” (line 468). Participant 8 suggested that leadership “knows we can’t leave...if you want to work in your specialty...you can’t go anywhere else” (line 469-471). Nurses suggested the hospital leadership had “almost magnetized themselves without being a magnet hospital, only by geographics” (line 473-474). Nurses believed they had to stay because they “love working with [patient population]” (participant 8, line 478), noting that “it’s not the place they like to work for...they don’t love working at the hospital” (participant 8, line 478-480). One of the reasons participants didn’t love working at the hospital was because they felt voiceless:

When presented with a change that we have huge reservations about for really legitimate reasons, I want to know what it is about our voice that it is so dispensed with? (participant 5, line 589-590)

Administration's dismissal of nursing knowledge throughout multiple change initiatives left nurses feeling that, "you don't feel like you have a voice or much of a say...you're the frontline people that are using these things all the time and they [leadership] don't care to ask" (participant 14, line 205-214). Nurses were upset because, as participant 6 noted, "we don't have a voice, despite being the biggest employee population" (line 280). The data does suggest that, on occasion, nurses were able to voice opinions regarding small items at the unit level that either supported a culture of service (proposed ideas for cost cutting or increasing efficiency), or items that, for example, did not cost money, "if it's a small change that doesn't cost any money, we have a voice, if it's a large change that might cost money, we don't have a voice" (participant 10, line 686-689). Participant 6 said, "I don't think anything really gets heard unless we're telling them [leadership] what they want to hear" (participant 6, line 291). Participants claimed that leadership wanted only to hear suggestions that did not cost the hospital money. For participant 10 "it became very clear that my opinion wasn't overly valued if my opinion led to the hospital spending more money" (line 546-547).

Small unit changes, where nurses had a voice and could contribute, were most often associated with the daily unit meeting (a Lean philosophy initiative). An example provided by participant 8 addressed nurses concerns that pharmacy would call the unit with multiple questions for nurses during morning shift report. Participant 8 volunteered to resolve the issue that resulted in asking pharmacy for a "block out period from 07:30 to 08:00. Don't call, let us get our shit together and then call, easy enough" (participant 8, line 541-542). However, participant 1 and 13 recounted a time that frontline nurses felt they had not been heard at the daily unit meeting when they had lobbied for a change initiative involving multiple nursing care units. Nursing staff recommended that a core group of nurses on each unit be trained to insert

intravenous catheters to improve quality patient care. The rationale was that the trained intravenous nursing team did not work overnight and worked only a few hours on the weekend resulting in delays if a patient requires an intravenous line insertion during those times. On one unit, nurses designed and distributed a survey to determine support for this initiative and to garner a list of nurses who wanted to be trained to be part of the unit's core intravenous group. But as participant 13 noted, "It was almost like a wasted project" (line 138) because it "never went anywhere" (participant 13, line 139). The rationale provided for denying this change and others like it were associated with their costly implications. Nurses quickly learned that "those sorts of changes were just not going to happen, whether we want them or not" (participant 1, line 343). Participant 6 pointed out, "we can say what we want, but if it's not in the budget, or it's not budget friendly, it's not going to happen" (line 284).

When it came to large, corporate level change initiatives, for instance, budget cuts involving nursing lay-offs, nurses were not involved, in decision-making: "there was not nursing involvement in discussions, unless you include nursing management" (participant 10, line 32-33). When participants raised their concerns about change initiatives already decided upon by leadership, or following "brief consultation that we [nurses] were allowed" (participant 5, line 62) many concerns were dismissed. "Nurses who were not keen on the changes, they weren't being given, they didn't feel they were being given very positive feedback for their point of view" (participant 1, line 464-466). When nurses, for instance, brought to light "major flaws [of the electronic documentation system], a lot of them having to do with retrieval of information, a lack of flexibility" (participant 5, line 65-66) leadership perceived their concerns as "just bitching, but you know they were legitimate complaints" (participant 5, line 1093).

When nurses foreseeable concerns materialized following change implementation, nurses were left questioning, "when our voice is not listened to, and then, when 5 years down the line it's proved that were right, I'm wondering why do you think our opinion is so valueless" (participant 5, line 74-75). The ongoing dismissal of nurse's voices was upsetting because;

“when you’re not listened to it’s a fight everyday to promote patient care and safety” (participant 12, line 302). Promoting patient care and safety are foundational in supporting a culture of care.

Nurses felt voiceless over their work scheduling. Since changing to a centralizing staffing structure, “staffing is ignoring them [nurses], they’re not getting a voice in the time they want [to work]...all kinds of stupid shifts they’re getting from staffing” (participant 9, line 674-676), while additionally, “they’re not getting to claim their vacation time” (participant 9, line 678). Participants wanted to “be asked for our opinion and actually listened to” (participant 9, line 1385). They suggested that “if you’re going to ask your nurses for an opinion and suggestions, perhaps once in a while you should actually listen, you should actually take that seriously” (participant 9, line 1386-1387). Participants communicated that “there needs to be a way for us to speak and actually be listened to” (participant 6, line 519).

### **Reducing Distress**

We seem powerless to speak up, powerless to raise one voice as a group of nurses in the hospital (participant 9, line 1517-1518).

Despite participants’ distress, their stories demonstrated they were not completely powerless. Although some participants perceived nurses as unable to say “‘no’, say ‘my goodness we’re not doing this’, [because] we don’t have the organization to do it” (line 1160-1162), they also acknowledge that some nurses appeared to counterbalance feeling powerless and disempowered with the willingness to take back elements of power. In micro-ethical moments of practice they prioritized patient caring activities over more service driven activities. For example, participants recalled overriding medication cabinet scanners, by manually verifying medications to avoid delays in medication administration. Participants also manually administered intravenous medication flushes instead of programming the smart pump. This avoided multiple interruptions to patients since programming medication flushes took multiple steps and incurred multiple patient interruptions. Participants who enacted this work around recognized that, “now it [manually administering medication flushes] might not have been the

way to do it but we stood there for a minute and did it and I still saved time” (participant 5, line 664-664). Participants argued in favor of this practice because, “nurses critically think, that’s what we went to school for” (participant 6, line 505), noting “it was easier to manually push then it was to run it on the pump, it’s safer too, I know exactly what I’m doing” (participant 11, line 630). Nurses possessed the critical thinking skills to determine when such actions were safe, and when they were not. They deemed that manual skills were safer for the patient because the nurse had many years of experience manually administering, and was more confident in their ability to safely and accurately perform the task than using a new technology they were not familiar with troubleshooting, or that was disruptive to patients.

Some participants refused to partake in standardized work processes that, for some, did not “make sense when I use my critical thinking skills” (p13), “really, if you think about it logically, why would you [follow the standard work]?” (participant 14, line 117-118). For example, participant 13 did not follow the standard work procedures for medication kit set-ups for specific high-risk groups. This participant still prepared the patient specific dose of the first medication to be administered from the kit in the event of an emergency, “I still drawn Benadryl up because that is the first medication we give if they’re having a reaction” (line 365). She chose to do this in her practice because when she thought critically about the use of the kits in an emergency, she foresaw a delay in care that could jeopardize patient safety in an emergency situation, “you have to fumble through all of these bags to get what you need...that’s compromising patient care” (line 357-366). Nurses exercised power in these micro-ethical moments by trusting their own critical thinking and judgment over standard work processes to deliver patient care.

Participants stated that many nurses did not see value in daily unit meetings, finding them “a waste of time” (participant 11, line 1008) “It’s a lot of pushing of the corporate vision” (participant 9, line 444), especially when nurses felt their time was already “spread so thin” (participant 11, line 794). Participants believed they had “better things to be doing...like

spending that time with parents and patients” (participant 11, line 1009), suggesting that, “if I have 15 minutes to stand here and listen to what the manager and educator is saying, I could spent 15 minutes with a family” (participant 13, line 441- 442). During this time nurses would “sit with them [patients and families], and listen to them and talk to them and get them through their day” (participant 13, line 442-443). This redirection of daily unit meeting time was important to nurses because “in the rest of day I certainly won’t have time to sit with them and talk to them” (participant 13, line 473). Participants recognized they “made a choice” (participant 13, line 444) to spend that time “with one of my families instead [of the daily unit meeting]” (participant 13, line 444). They determined “who was more important and made that conscious decision” (participant 13, line 457).

Nurses recognized the paradox of being given a venue to voice unit level concerns, in which they chose not to be involved. Increased work demands and learning curves associated with rapid and continuous changes, loss of time to other responsibilities and activities, and the fact that taking ownership for a concern at the daily unit meeting meant additional work left nurses deciding to redirect their energies towards direct patient care activities. Even though they were “covertly in trouble, and questioned about why we made those decisions” (participant 13, line 310). Choosing to engage in activities oriented to a culture of care rather than the culture of service proved challenging, and at times distressing, as it was nurses’ moral imperative to care that was repeatedly at stake.

Others took steps to take back power over certain elements of their work life, which included refusing to pick up additional work hours: “I don’t pick up any extra shifts. Don’t call me. I’ve put in my time and for me that’s enough” (participant 9, line 618). Participants refused extra shifts because, “That time [at work] is extremely stressful and if I didn’t balance that craziness with a life outside of it, I wouldn’t do it [nurse]” (participant 9, line 619-620). Alternatively, some participants, if asked to pick up an extra shift, would explicitly “ask, ‘am I the only senior staff [working this shift]’, then I actually have a choice, ‘do I want to put myself in that situation

[working with a disproportionate amount of inexperienced or float nurses]?” (participant 12, line 354-358). Other participants removed themselves from committee work, “I stopped [my involvement]” (participant 2, line 57) because of ongoing feelings of voicelessness and powerlessness, “somehow there’s always a last word no matter how much work and effort you put into the committee” (participant 2, line 59).

Participants disengaged from activities that did not reflect a culture of care, or that did not, in their opinion, enhance patient care delivery, “You don’t engage yourself with management and the corporate stuff that’s going on, you just cut yourself off from that side of it, you focus on your patients” (participant 13, line 412-413). Another participant described her means of disengagement: “I’ve kind of disconnected from the politics...when you don’t [disconnect] you see more of the problems and things that frustrate you, what frustrates you about work is more in your face and you see it more” (participant 14, line 639-641). Other participants separated themselves from organizational politics, “Now I don’t get into the politics” (participant 8, line 790) which, for this participant, “completely unburdened” (participant 8, line 799) her because “when you don’t get into all the politics you can listen in the lunchroom, you can eat your lunch and get up and walk away and say ‘thank God I don’t have to deal with that’” (line 797-798). Participants justified extricating themselves from organizational politics in order to decrease their multiple frustrations regarding rapid and continuous changes. This freed up their energy to focus on direct patient care activities. Disengagement from activities that did not reflect a culture of care allowed nurses to focus on aspects of work that met their moral imperative related to patients.

Some participants manipulated discursive practices to gain back access to adequate resources and consistent preservation of patient safety that were compromised during multiple change initiatives. Many participants raised concerns about the way their work was disrupted or would need to be restructured in order to accommodate new equipment, but they were not heard by management. Arguments grounded in patient safety concerns, however, were more

often met with approval and support. Nurses provided examples of ways they governed their own discourse so it fit within dominant ideologies, such as patient safety, to support their rationale for clinical decision-making:

You had to be very careful about phrasing things with [the manager]. If you didn't phrase it in a way that had a patient safety focus you didn't get what you wanted (participant 11, line 278-280).

Interestingly, participants who more often felt heard focused their concerns on patient safety and integrated risk and safety language when speaking to management and leadership.

## Chapter 7: Discussion

Participants' experiences illuminated what critical management scholars Linstead, Maréchal and Griffin (2014) refer to as the dark side of organizations: the messy human complexities existing within organizations that have traditionally been "overlooked, ignored or suppressed" (p. 166). The dark side Linstead and colleagues speak of resides within organizations: within their boundaries and within their practices, yet very little of this obscurity is reflected in health care scholarship. Examining the inner workings of organizations through a critical lens brought to light some of the darker sides of organizations. These aspects of organizations reflect a shift in interests from systems to the inner workings of the people within systems (Linstead et al., 2014). This allows for the examination of those who are overlooked or represented in limited ways so the complexities of their experiences are poorly captured or understood. In keeping with the critical underpinnings of this study, the findings and ensuing discussion (re)position overlooked or underrepresented experiences at the forefront, acting to validate those experiences even when they stand in stark contrast to dominant discourses and portrayals of organizational life.

Participants' experiences of change brought forth narratives that spoke of deeply rooted ideological struggles of care versus service that fostered morally challenging situations for nurses. Participants embedded their experiences within notions of loss, the (in)ability to speak, the (in)ability of others to hear, and the associated negative impacts on nursing work and patient care delivery. I suggest these notions reflect the darker side of organizations. Participants' experiences illuminated nurses' understanding of themselves and their voices in relation to others, society, histories (both individual and collective), and the culture of health care. They provided data for a unique, rich, complex analysis of nurses' organizational lives. The analysis highlighted the intersection of relationships that were embedded in nurses' working lives during rapid and continuous organizational change.

### **Nursing's Voice as a Counter Narrative**

There has been overwhelming support for organizational change in health care, most notably from management experts. Benefits of such changes have been narrowly defined in terms of efficiency, financial performance and a requirement to adapt to fast-changing technologies (Morgan & Spicer, 2009), all elements that appear to reflect a culture of service. Such discourses have been widely critiqued by critical management scholars (Alvesson & Deetz, 2000; Child, 2009; Dellifrairie et al., 2010; Fulop & Mark, 2013; Gilbert, 2005; Knights, 2009; Moraros et al., 2016; Morgan & Spicer, 2009), nonetheless, many managerialist practices continue to exist as taken-for-granted truth claims within HCOs (Beardwood et al., 1999; Cope, Jones & Hendricks, 2016; Goodman, 2014). The complex ways in which rapid and continuous change impacts relationships (nurse-patient, nurse-family, nurse-nurse, nurse-management, nurse-health care system) have been largely omitted from managerial discourses.

A counter narrative is needed to address the increasing complexities within HCOs where nursing care takes place. This study proved to be a timely endeavor to problematize the phenomenon of organizational change in health care. Research facilitated critical examination of the strong ideological shift to service delivery that may be inconsistent with the ideologies of care that underpin the nursing profession. According to nursing scholars Holloway and Freshwater (2007), "counter narratives and alternative explanations are often attempts by people to prevent the loss of their identity and not passively accept the ideas that others impose on them" (p. 708-709).

### **Voice and the Capacity to Listen**

As articulated at the onset of this dissertation, the way voice has been conceptualized here is influenced by the later works of Michel Foucault in his 1980s Collège de France lectures. For Foucault, the fundamental importance of voice lies in the way it reveals conflict between voices embedded in our relationships (Siisiäinen, 2012). Voice provides a way of sharing one's

identity and articulating one's truths. It is how individuals speak unique truths created by the plurality of one's voice in relation to the self, other, culture, society and history. Although voice originates from an individual, it reflects the relationships between self and a multitude of others. These relationships often exist in tension and greatly influence how we experience being in the world.

Voice reflects both power and oppression. It is political because of the ways it is given and received facilitates the struggle over knowledge. Voice reflects the limits and possibilities of knowledge discussed by Foucault, speaking to tensions between governed and governing (Foucault, 1980). From a moral perspective, voice can represent vulnerability and a loss of sovereignty and self-sufficiency (Siisiäinen, 2012). In the context of this study nurses' voices reflected a political and moral quality when they described their experiences of multiple change initiatives. Voices may become muffled when they seem threatening from the point of view of a governing discourse (Siisiäinen, 2012).

Voice differs from discourse. Discourse is understood by Foucault as ways of constituting knowledge, working alongside social practices, subjectivities and relations of power to mediate relationships between multiple discourses (Foucault, 1980). Discourse is a higher level of abstraction and I suggest it shapes what voices are heard and validated. Participants constituted their subjectivity when speaking about their voice in relationship to power, often describing it as powerless and unheard. This manifested itself in the construction of their subjectivities as governed by managerial discourses and practices that had power over nurses and their practice.

Participants described feeling voiceless, and at times silenced in their practice. The transition from voiceless to silence requires further examination. It is important to note that not all aspects of nurses' voice were dismissed at all times: nurse participants recounted various times when they could speak. For example, nurses could partake in consultations organized by leadership prior to the purchasing of new intravenous pumps and medication cabinets.

Consultations took place in order to collect nurses' opinions and gave them opportunities to ask questions, offer suggestions or convey concerns. As such, from the perspective of leadership, nurses were given a voice in decision-making, regardless of the extent to which their feedback influenced decisions. If nurses had a venue to voice their perspective, then, perhaps what needs to be examined is what, in their discourse, resonated (or not) with administrators.

Some participants found ways to be heard by mobilizing concepts (e.g., patient safety) that were consistent with leaderships' priority concerns. It is important to highlight that when nurses use language familiar to managers (e.g., quality assurance; risk management) effects can be both productive and counterproductive. Using language familiar to managers to relay nursing concerns suggests a confluence of concerns between management and frontline nurses, which appeared to bring about consensus in the organization. Yet, nurses' and managers' conceptualizations may have differed on certain issues. "Patient safety", for example, is a prevalent concept in nursing and HCO discourse. In this study however, it seemed to be understood differently amongst nurses and managers, participants' accounts suggest that these notions signify different things for nurses. For example, when nurses raised concerns about patient safety relating to new intravenous pumps, managers responded that they too were focused on patient safety, which is why nurses had been provided with smart pump technology – a safeguard to enhance patient safety. Nurses' concerns regarding patient safety referred to their inability to override the smart pump technology, which led to a patient's life being endangered.

"Family centered care" is another example of a value that is central to both nurses and health care leadership yet can be understood in very different ways. For example, the site where the study took place defines "patient centered care" as meeting the physical, developmental, social and emotional needs of patients and families. Participants in this study discussed "cuddling babies" as an example patient caring activities that was negatively affected by rapid and continuous change. In particular, they criticized the loss of time required to cuddle

babies, which was construed as a significant problem because considerable nursing care (e.g. assessment; therapeutic touch) took place during that activity. The literature shows that such activities carry significant benefits for infants. Therapeutic touch in the care of infants decreases pain (Gray, Watt & Blass, 2000; Johnston et al., 2003; Peters, 1999) decreases stress (Johnson, 2005; Peters, 1999) and promotes self-regulation of sleep-wake cycles (Feldren et al., 2002). Clinical assessments of the infant also occurred during cuddling, which included movement patterns and levels of responsiveness; fundamental assessment criteria for this patient demographic (Leifer, 2011). Nurses simply described this as the loss of time to cuddle babies without conveying the clinical and therapeutic significance of that work. This omission may be due to nurses taking such care for granted. As a result, nurses' concerns made sense to nurses but not necessarily to those removed from direct patient care or educated in another field (e.g., management). Nurses' language about infant care likely did not withstand the discursive expectations of professional, evidenced-based care despite its legitimate clinical impact. It was not articulated in a way that would resonate with managerial discourses. Therefore, these kinds of nursing concerns were often dismissed by leadership, despite being consistent with the institution's explicit focus on "patient centered care". Discursive misalignment between nurses and managers led to a selective uptake of nurses' concerns and to nurses feeling unheard and silenced by the organization.

The concept of silence is as important as that of voice. Svensson, a prominent critical management scholar contends, "A thorough exploration of the everyday production of organizational culture would need to take into account a study of silent voices and themes" (2014, p, 181). Two forms of silencing were noted in nurses' accounts. The first form of silencing, described by Svensson (2014), is the unsaid, which comprises "those things we take for granted, the common sense that we never really talk about" (p. 182). This first form of silencing was noted in nurses' experiences when they reflected on the purpose of change. They recognized they were led to believe that change is always good and necessary in contemporary

HCOs, and that they were to accept changes without question. The second form of silencing, also described by Svensson (2014), is the not-said, comprised of “all that which has been excluded and repressed from everyday life: all the themes, topics, metaphors, motifs, discourses and images that have been excluded from the conversations that occur in the organization” (p. 182). Exclusion occurs when everyday reproduction of the dominant organizational discourses prioritizes the importance of certain forms of knowledge and knowers, while downplaying others (Svensson, 2014).

Nurses recognized this second form of silencing as predominant in their day-to-day practice, most notably through the overlooking or dismissal of nurses' concerns regarding change initiatives and the ramifications, including increased workloads, compromised patient safety and decreased staff morale. Svensson (2014) further articulates, “some themes and topics are actively, and consciously, excluded from social interaction in the daily life” (p. 182).

Participants felt silenced by leadership and recounted multiple examples that included the lack of open door policies and experiences that humiliated nurses. They felt they had to “beg” for additional staff to ensure the delivery of safe patient care. Such examples explain why individuals felt unheard, voiceless and silenced. To date much research on organizational communication has focused on speaking, and the concept of voice, whilst underserving the notion of hearing (Catlaw, Rawlings & Callen, 2014) and its potential relationship to the silencing of others. There are ways in which organizational researchers can place those silenced voices at the forefront of research. To do so, Svensson (2014) suggests that the interpretation of data must go beyond “the manifest text ...and common-sense assumptions of what the silence is silent about” (Svensson, 2014, p. 183).

Silencing occurs when individuals feel unable to speak or when individuals are not heard. This means the role of listening cannot be overlooked when examining the complex relationships between silence and voice. The role of listening in constructing the concept of voice was explored in this study, because, “discourse and dialogue ultimately involve both the

capacity of someone to speak and someone else to listen” (Catlaw et al., 2014, p. 198).

Participants described their discursive relationships with leadership in terms of “not being heard” (participant 2, line 76), “not being listened to” (participant 12, line 301) and “not having a voice” (participant 6, line 317). These repeated choices of phrasing from multiple participants are significant because they reflect the relational responsibilities of both speakers and those who are expected to listen. The act of listening (or alternatively the act of not listening) in complex organizations reflects multiple frameworks of power and hierarchy that act in both empowering and oppressive ways.

Listening is important because it can empower people. Those given the relational responsibility to listen can enable or disable speaking opportunities to be authentically heard (Catlaw et al., 2014). Participants described brief consultation periods for some change implementation, and a daily unit meeting, as places to voice concerns. In spite of these forums, nurses perceived their fundamental concerns were not heard in authentic or genuine ways, exemplified by participant 8’s use of the “smokescreen” (line 364, 826) metaphor. Participants felt uncomfortable speaking against dominant organizational change discourses that informed much decision-making within their workplace. Participants interpreted limited opportunities to be heard as a reflection of their low importance and value within the institution. When they did take advantage of such opportunities to question decision-making, they observed that their concerns were dismissed.

Listening is understood as “an embodied ability, a way of knowing, a moral capacity” (Stivers, 1994, p. 365). There is a moral component to listening that participants in this study described in consequential terms. They recalled their predictions of how many of the change initiatives could compromise patient care, and even jeopardize patient safety, yet, in the planning stages of change, these concerns were dismissed. Many of the nurses’ predictions materialized, resulting in morally distressing experiences. As such, from participants’ points of view, those in leadership who dismissed nurses’ concerns did not uphold their duty to listen,

thereby breaking the reciprocal nature of speech acts. This example reflects the relational nature of listening, where listening “is a practice of relating to the self and others that puts one in a position both to receive and speak ‘truth’” (Catlaw, 2014, p. 206). Listening is a way of knowing (Stivers, 1994). In the data from this study nurses’ ways of knowing and thus truths were challenged in a field of competing truth claims where managerial knowledge were rationalized to support the implementation of changes. Other truth claims such as budgets and efficiency took precedence and neutralized nurses’ voices. From the nursing standpoint, they perceived themselves as not having a voice, but at the same time they were aware of the competing truths within their workplace.

Nurses provided few examples of their voices being heard. When they were indeed heard, it was most often when their voices supported the broad tenants of managerialism, for instance, when they spoke in favor of current corporate priorities, specifically in terms of budgetary or efficiency driven discourses. When conversing with management, nurses must gain epistemic legitimacy through rhetorical tactics that justify their knowledge in ways that align with managerial knowledge and upon which leaders base health care decision-making. Participants often described ways in which their voices were not heard within their organization. What appeared to go unheard were concerns that supported a culture of care, including addressing the loss of time and resources required to provide quality patient care. These things mattered more to nurses than efficiency and budgetary concerns. Traynor’s (2012) research reflected similar findings: “nurses appeared acutely aware that care could vary in quality and that good quality caring demanded, above all, adequate time” (p. 147). Participants also felt they were not heard when raising concerns regarding lack of support and training, and low staff morale.

From a managerial perspective, managers could argue that nurses were given training and support. Participants contended that what was provided was insufficient and did not adequately address their learning needs. The data suggests that a broader nursing discourse

grounded in *care*, (e.g., nurses asked for adequate time and resources to *care*) was not met with the attention that nurses expected from the leadership of a care facility. Nurses' requests for resources such as time and decreased workloads in the name of care has been described by Bent (1993) as exercising political acts of caring. Yet, administrators heard nurses' requests in terms of cost and budget limitations, which are common management priorities (Dickson, 2009; Elrod & Tippett, 2002; Steiger, 2009; Weiner et al., 2008). Nurses had clear expectations towards leaderships' uptake of their concerns. As a result, when they were not heard in the intended way, they became frustrated and disillusioned. The literature suggests that frustration and disillusionment is increasing amongst frontline health care workers as managerial ideals and values increasingly shape health care decision-making (Cope et al., 2016; Lewandowski, 2003; Shannon & French, 2005; Traynor, 2012).

Participants assumed that their voice would make it all the way to the people they were speaking to (e.g., management/leadership) as intended. The listener (management/leadership) utilized a series of filters, which were increasingly governed by managerialism whereby some information and concerns made it through and others did not. The multiple filters in which voice is received are dependent upon particular political ideologies that give credence, or not, to certain constructs and objectives. Leadership in that setting appeared to prioritize efficiency and cost cutting which heavily influenced the legitimacy and urgency of what nurses communicated.

Nurses assumed that voice would travel unfiltered to management and leadership so feeling unheard contributed to their distress. Interestingly, participants recounted management doing certain things to support nurses during periods of rapid and continuous change, but these point to management having a particular understanding of what nursing practice entails. For example, the technical aspects of nursing work were supported by the organization through in-services on how to use new technologies. Conversely, the organization did not support nurses as critically thinking, skillful, autonomous professionals, who challenged rationale for changes. These findings re-iterate findings in both nursing (Austin, 2011; Dent & Burntney, 1996;

Goodman, 2016) and critical management literature (Alder, 2009; Alvesson & Deetz, 2000; Fleming & Mandarini, 2009; Fournier & Grey, 2000; Thompson & O'Doherty, 2009) that suggest workers are increasingly seen as technicians in contemporary organizations (Rankin & Campbell, 2006).

Within the managerial inspired discourse that guided organizational change implementation it can be argued that there is little room for nurses as professionals, while nurses as technicians are valued. The criterion that defines a profession includes a specialized body of knowledge, control and authority over training and education, an altruistic mandate, accountability, ethics, and autonomy over practice (McEwan & Wills, 2014). These criteria extend professional practice beyond technical work, and more explicitly articulate the moral values that underpin practices of the professional. However, embodiment of these values is not often measured in significant or meaningful ways within managerial inspired perspectives. It is difficult for nurses to practice to the full extent of their professional standards within managerial discourses that value quantifiable outcomes over processes. Nurses in this study felt they were allotted only the amount of time to complete tasks. This significantly changed how nurses provided care. Nurses felt they were no longer given the time necessary to provide "good" (participant 9, line 1115), "safe" (participant 1, line 737) or "quality" (participant 5, line 1072) care, instead only being given the time to provide service. Such transformation of caregiving practices has been highlighted in the literature:

Many administrators believe that performing medical tasks is more complex, and thus a better use of nurses' time, than providing comfort measure or listening to patients' concerns...Medical tasks should not eclipse the importance of ensuring patient comfort and safety within the context of a caring relationship that enables nurses to get to know patients as individuals (Gottlieb, 2014, p. 27).

To remedy the loss of time nurses requested more resources (time), training and power over change initiatives and thus the structuring of their work. According to Kuokkanen et al.

(2007) these are common requests of frontline nurses during change. Participants suggested that leadership provided watered-down versions of what nurses asked for, gave training that was deemed inadequate, or consulted nurses but did not integrate their feedback into organizational change decision-making. Participant 8 described this watering down by using the “smokescreen” metaphor, and participant 5 described this as “play[ing] the puppet” (line 251). Such examples illustrate competing truth claims between frontline workers and leadership, which is consistent with much critical organizational scholarship (Alvesson & Deetz, 2000; Dent & Whitehead, 2002; Harlow et al., 2013; Knights, 2009; Olakivi & Niska, 2017; Shepard, 2017; Thomas, 2009; Thompson & O’Doherty, 2009). Amidst competing truth claims, those that supported a culture of service appeared to take precedence. The resulting inability to uphold a culture of care fostered moral distress among participants.

### **Emotional Work and Moral Distress**

The (mis)implementation of change initiatives in the study site created problems that were described by participants as being more than mere inconveniences in nurses’ day-to-day practice. In describing and problematizing the impacts on care provision and nurses’ relationship with “others”, participants’ mobilized arguments grounded in morality and ethics. Morality and ethics arose across a range of elements: the (in)ability to speak and to (not) be heard, the legitimacy of knowledge and truth claims, and subsequent concerns of power and politics.

Emotional work is understood as work required “in order to do the job of creating an environment of care” (Gattuso & Bevan, 2000, p. 893), and is part of the nursing repertoire. Gattuso and Bevan (2000) define emotional work as a positive experience, one that builds human connection, a key concept developed throughout the findings. The use of the word *care* is significant when examining the ideological tension of care versus service and the resulting erosion of environments conducive to caring described in the findings.

Creating an environment of care calls upon nurses' abilities to empathize with patients, a key component of emotional work (Hochschild, 1983). Over time the concept of emotional work has received much attention in nursing literature, highlighting both positive (Henderson, 2001; McQueen, 1997;) and negative (Ashkanasy, 2001; McVair, 2003; Raines, 2000) impacts on nurses. As noted in the literature review, "the phenomena of work cannot be disentangled from broader questions of identity and dominant discourses that frame the self and his/her life project" (Fleming & Mandarini, 2009, p. 335). Participants in this study described engaging with emotional work as a necessary and fulfilling part of nursing work and the ideal nursing identity. Participants understood emotional work as a fulfilling act in and of itself, not one that caused distress. What caused distress were organizational structures in place, specifically those that drove rapid and continuous organizational change, that prevented nurses from engaging in aspects of emotional work. In light of workplace changes, participants saw the erosion of their emotional work, which fueled feelings of inadequacy and failure. Nurses perceived this erosion as detrimental because it symbolized an irreconcilable ideological clash (care versus service) in changing health care landscapes that negatively impacted their capacity to nurse in ways that were authentic and brought them fulfillment and satisfaction.

Emotional work fosters human connection: "it is at these moments of skillfully enacted emotion work when truly human connection occurs" (Bolton, 2007, p. 9). Participants described how loss of time to engage in emotional work and the subsequent loss of human connection translated into repeated and prolonged feelings of inadequacy. Meaningful relationships are the product of engaged emotional work, which so often in task oriented environments becomes invisible work (Bone, 2002). Gottlieb (2014) notes this as problematic: "When all of health care is seen to be quantifiable, nursing is practiced as a set of technical activities rather than a set of relational, social, and moral activities with a technical base" (p. 27). The data in this study supports the understanding of nurses' relational, social and moral activities as emotional work.

When analyzing how participants constructed themselves as nurses amidst the aforementioned changing health care landscape, a discourse grounded in moral distress emerged. Nurses constructed care through a profoundly moral lens; inability to abide by this imperative resulted in moral distress. Moral distress, an unexpected finding in this study, moves beyond the current understanding of nurses' experiences of change, which, as discussed in the literature review, highlights experiences of stress, burnout, exhaustion, voicelessness, powerless and disempowerment (Barrett, 1983; 1989; Copnell & Bruni, 2006; Hertting et al., 2003; Jones et al., 2008; Korunka et al., 1993; Kuokkanen et al., 2007; McGibbon et al., 2010; Purcell & Milner, 2005; Tholdy Doncevic et al., 1998). No connection to moral distress has been made. Moral distress is "an umbrella concept that describes the psychological, emotional and physiological suffering that may be experienced when we act in ways that are inconsistent with deeply held ethical values, principles or moral commitments" (McCarthy, 2013, p.1). Carnevale (2013) further articulates that:

Moral distress generally refers to an experience when a person knows what is right to do but does not do it because of external or internal impediments to the person's actions. In nursing, this can refer to feelings such as frustration, guilt, anger, or powerlessness resulting from situations where a nurse is actually - or believes she is - constrained from acting in an ethically right manner (p. 35).

McCarthy and Carnevale offer important conceptualizations that facilitated identification of moral distress in this study. Participants described feelings of anger, guilt and powerlessness in response to change initiatives that constrained them in their day-to-day work. Data suggests that the inability to act, or taking no action when one felt action was warranted, produced moral distress, thus moral distress was noted in the ways in which participants were unable to act. Andrew Jameton (1984) was the first to notably describe the concept of moral distress in nursing. He articulated that moral distress is fuelled by institutional policies and practices that constrain nursing practice. This definition is still of significant relevance, as managerialism and

associated discourses are increasingly restructuring, redefining and governing nursing practice in contemporary HCOs. In addition to identifying these emerging constraining organizational factors, it is equally, if not more important, to understand how they impact nurses in their day to day practice; in other words, to examine those moments in which nurses describe moral distressing experiences. Participants' narratives outlined the multitude of organizational factors that contributed to nurses' experiences of moral distress and the resultant challenges to the enactment of authentic nursing practice during periods of rapid and continuous change. Participants described many occasions where they felt unable to fulfil their moral responsibilities to patients, families, colleagues and the profession of nursing. Nurses experienced morally distressing experiences during "micro-ethical" moments with patients and families, described by Troug et al. (2015) as that which "is unique to each situation, arises spontaneously at a particular moment in time, and is created in the relational space between the participants...and it is directly applicable to the front lines of practice." (p. 11). Participants felt unable to uphold the tenants of a culture of care, which shaped their moral imperative. Currently, this culture of care is threatened in the wake of a growing culture of service (Austin, 2012). It becomes harder to uphold a culture of care within "a climate of increased managerialism" (Maben, Latter & Clarke, 2007) that has increasingly shaped the last two decades of health care (Ackroyd & Bolton, 1999; Cooke 2006; Traynor 1999), in which notions of efficiency, performance objectives, resource constraints and cost effectiveness are paramount (Wells 1999; Wong 2004).

Canadian researchers Armstrong and Armstrong (2003) argue that health care management decisions are often made on the knowledge of money and profit, as opposed to knowledge of health, an argument also put forth by study participants. Their arguments are supported by Wells (1999) and Wong (2004), who argue the paramount priorities of contemporary health care management are shaped by efficiency, performance objectives, resource constraints and cost effectiveness. Austin (2012) articulates the impact of such re-orientation to health care, "The re-engineering of health care to give precedence to corporate

and commercial values and strategies of commodification, service rationing, streamlining, and measuring of 'efficiency' is literally demoralizing health professionals" (p. 27). Goethals, Gastmans and Casterlé (2010) note that health care professionals struggle to cope with the ethical dimensions of care in health care systems that focus heavily on cost containment. Hayes (2000) further articulates this shift in health care as it relates to ethics: "In the realities of clinical ethics today, nurses face rapid reorganizations, changing technology, resource challenges...Nurses' sense of their own moral agency can be challenged on a near-daily basis." (p. 90).

In a growing culture of service, participants felt unable to maintain the high level of connection with fellow nursing colleagues they had come accustomed to, which led to the fracturing of the nursing community of practice. This loss deeply distressed participants. Communities of practice have three unique characteristics, mutual engagement, joint enterprise, and a shared repertoire (Wenger, 1998), all of which were fractured by an ideological shift to a culture of service. Mutual engagement is the building of relationships and negotiating a shared understanding of actions (Wenger, 1998). Participants' ability to build relationships was disrupted by the loss of time to engage in such activities while at work and burnout that leached the energy of individuals to do so outside of work. Sense making associated with nursing actions was disrupted when nurses felt their actions were not reflecting a culture of care. Joint enterprise is the common set of entities that members of the community of practice could influence (Wenger, 1998), which for participants was patient well-being. When participants no longer felt they had the influence required to enact their moral imperative to protect patient well-being, their community of practice began to shatter. Shared repertoire includes the acknowledgment of shared routines, tools, symbols and stories that define the community of practice. Shared routines for participants included the completion and documentation of nursing assessments. Tools included the critical thinking elements of nurses' work, vis-à-vis nurses' intellectual tools, which facilitated prioritization and delivery of care activities. Multiple

organizational changes based on an ideology of service disrupted participants' routines. For example, technology now mediated nurses' assessments and documentation. Documentation technology "shattered" (participant 5, line 101) patients and the abilities of nurses to create holistic patient stories. Similar findings have been reported by Varpio et al. (2015). Nursing tools were replaced by technologies that were believed to be "more trustworthy...or more accurate" (participant 5, line 746-750) than nurses. The lost nursing narrative was understood as a both a symbol and a story that uniquely defined nursing. This was replaced by a predominately binary tick-box system, effectively reducing nurses to "fucking box tickers" (participant 5, line 155). Pyrko and colleagues (2017) suggest communities of practice cannot exist without an additional characteristic, "thinking together" (p. 390), a process that facilitates the sharing of tacit knowledge. Tacit knowledge, knowledge acquired from expertise (Polanyi, 1966) is an extremely valuable and important form of knowing in nursing (Dehghani, Jahromi, Ganjoo, Akhundzadeh & Ganjoo, 2013; Herbig, Büssing & Ewert, 2001; Kelly & Hager, 2015; Lake, Moss & Duke, 2009; Meerabeau, 1992; Welsh & Lyons, 2001). Tacit knowledge is said to both "organize and give meaning to practice" (Salter & Kothari, 2016, p. 20), which are important to identity forming (Salter & Kothari, 2016).

The findings from this study suggest that nurses felt their workplace discouraged them from critically thinking, exemplified through multiple deskilling practices where participants felt reduced to "robots" (participant 13, line 343). Participants also suggested that opportunities where tacit learning occurred, for example, storytelling, during "lull periods" (participant 8, line 703) were far and few due to loss of time and resources. Such forms of knowledge translation are practices of social learning, an important way in which health professionals learn (Salter & Kothari, 2016). From the perspective of Pyrko and colleagues (2017) the loss of "thinking together" and subsequent negative impact on tacit learning could further fracture a nursing community of practice.

Communities of practice socialize nurses into the profession (Wegner, 1998). Learning is an important component of socialization because “learning entails a social formation of a person” (Pyrko et al., 2017, p. 389) which fosters a sense of belonging (Andrew, Tolson & Ferguson, 2008). Learning opportunities provided via communities of practice create a space in which nurses can analyse their practice, share knowledge, and problem solve together (le May, 2009; Wenger, McDermott & Synder, 2002). Strong communities of practice create distinct epistemic cultures (Knorr-Cetina, 2000) which act as portals to identity construction (Andrew, Ferguson, Wilkie, Corcoran & Simpson, 2009; Andrew et al., 2008; Pyrko et al., 2017). The distinct epistemic culture that shapes nursing identity reflects a culture of care, thus it not surprising that the literature suggests that strong nursing communities of practice enhance patient care (Wenger et al., 2002). Nursing communities of practice strive to uphold a culture of care, which has, historically, shaped nursing’s professional identity (Arreciado Marañón & Isla Pera, 2015; Curtis, Horton & Smith, 2012).

Core elements of a culture of care described by participants included “patient advocacy” (participant 11, line 76), “doing what’s best for the patient” (participant 13, line 631), “contact with patients...supporting patients” (participant 9, line 404-406) and “good” (participant 9, line 1115), “safe” (participant 1, line 737) and “quality” (participant 5, line 1072) patient care. A culture of care supported “exceptional nursing care” (participant 8, line 174). Nursing’s professional identity has emerged from caring and compassion towards patients (Arreciado Marañón & Isla Pera, 2015; Curtis et al., 2012), a “concern for patients and a commitment to their well-being” (Traynor & Buus, 2016, p. 186). Core elements of compassionate care include being empathetic, holistic and “doing what is right for the patient” (Traynor & Buus, 2016, p. 187). A strong sense of professional identity is imperative to the delivery of quality nursing care (Kelly, Watson, Watson, Needham & Driscoll, 2017). Upholding the commitments associated with nursing’s professional identity has become “the core of the [nursing] professional’s personal satisfaction” (p. 186). However, “the ability to embody these ideals is blocked by the

organisation of work that features high patient throughput combined with...losing the opportunity to develop 'holistic' relationships with patients" (Traynor & Buus, 2016, p. 187). Competing demands and agendas, such as those between a culture of care and a culture of service, impeded or disable nurses abilities to consistently provide quality nursing care (Jones, Strube, Mitchell & Henderson, 2017; Tierney, Seers, Tutton & Reeve, 2017). Navigating challenging workplace relationships (for example, authoritarian styles or leadership) and pressures to "complete tasks within a required timeframe" (Henderson & Jones, 2017, p. 65) contribute to nurses' inabilities to provide quality nursing care, and uphold their moral imperative.

Professional identity can be disrupted by marginalization and workplace conditions that discourage open communication (Henderson & Jones, 2017; Kelly et al., 2017). Data suggests participants in this study felt unable to engage in open dialogue with leadership, and subsequently felt marginalized when advocating for an environment that supported a culture of care. This further contributed to the dismantling of nurses' identity.

Dismantling of nursing identity through a growing culture of service resulted in moral distress. This finding is not unique. Exposure to practice settings that do not enable nurses to uphold their idealized nursing identity results in distress (Maben, Latter & Clarke, 2007). Ethics is by no means new to nurses or health care, but increasing managerialism and the emergence of subsequent phenomena, for example rapid and continuous change implementation, raises new ethical concerns and dilemmas unique to contemporary HCOs. A pressing concern emerging from the data is that a culture of care and a culture service are mutually exclusive, in that to provide service, nurses must sacrifice care, and thus feel unable to uphold their idealized nursing identity. This perception of mutual exclusivity greatly contributes to nurses' experience of moral distress. Some literature suggests that health care delivery models can successfully balance key indicators of a culture of service; efficiency and fiscal restraint, and a culture of care (Hinno, 2012). The most influential factor appears to be the use of a democratic style of leadership; most notably through the use of participative management and shared governance

models (Gordon, Rees, Ker & Cleland, 2015; Gunderman, 2009; VanVactor, 2012). Such methods of leadership strive to ensure that multiple parties “work together towards the enhancement of health practices and processes” (VanVactor, 2012, p. 557). Traditional organizational structures of leadership that have been said to “extend command and control” (VanVactor, 2012, p. 558); akin to the dictatorship style of leadership described by participants, is ineffective in contemporary health care. The human capital of all is required to solve the complex issues facing health care systems (VanVactor, 2012).

It is the responsibility of those in health care leadership to ensure efficient and effective care delivery, but this must be done in ways that support the caring work of nurses (Pillay, 2011). These findings support the experiences of participants. Participants who experienced democratic styles of leadership suggested they felt more supported in their work. Albeit, participants did not always agree with the rationale for change initiatives, and the associated increased demands being placed on nurses, compromises to ensure elements of a culture of care appeared to be easier to establish and uphold. Acknowledging and acting upon nurses concerns in relation to upholding a culture of care serves to validate nurses’ professional identity (Kelly et al., 2017). When nurses feel their professional identity is validated and supported, it is less likely they will experience distress (Traynor & Buus, 2016; Henderson & Jones, 2017). For a culture of care to exist and thrive, leaders must value the tenants of such a culture (Henderson & Jones, 2017). All directives of organizational policy and leadership must foster a culture of care (Jones et al., 2017). Nurses wishing to provide a culture of care “on it’s own, is insufficient to ensure this transpired” (Tierney et al., 2017, p. 174); health care providers must work in environments that support them to uphold a culture of care (Tierney et al., 2017). The greatest obstacle in ensuring such supportive styles of leadership is a knowledge gap in terms of leadership development (Arroliga, Huber, Myers, Dieckert, & Wesson, 2014; Collins & Holton, 2004; Cummings et al., 2008; Richardson & Storr, 2010). Health care leaders are expected to facilitate change initiatives in health care organizations, which can be stressful, exhausting

(Arroliga et al., 2014) and even foster moral distress (Ganz, Wagner & Toren, 2015; Marres, 2006; Mitton, Peacock, Storch, Smith & Cornelissen, 2010; Porter, 2010). Nonetheless, their training and preparation for such roles remains haphazard and inadequate (Arroliga et al., 2014; Collins & Holton, 2004). In addition to narrowing this knowledge gap through formal, theoretical, leadership training (Arroliga et al., 2014; Collins & Holton, 2004; Richard & Storr, 2010), leaders could too benefit from establishing and maintaining strong communities of practice, both with circles of leadership and transcending to include frontline nurses. This could enhance their leadership skills and decrease the risk of morally distressing experiences. Nurse leaders in particular, if provided the training and support necessary to excel in health care leadership, could play an invaluable role in bridging a culture of service an a culture of care.

A culture of service is associated with challenging work environments. There is a mounting body of literature suggesting that nurses are increasingly finding their work environments to be “morally uninhabitable” (Peter, Macfarlane, & O’Brien-Pallas, 2004; Vanderheide, Moss & Lee, 2013), understood as a situation where nurses feel unable to provide morally sensitive care because of multiple factors challenging and changing their practice and practice environments. The data from this study supports the notion that tensions brought on by the perceived clashing of health care ideologies (care and service) can render nurses’ work environments morally uninhabitable. Participants reported conflict when describing institutional decision-making that did not align with their own philosophies of care. Participants felt they were sacrificing care, an ideology of paramount importance to them, in order to provide service and fulfill what they deemed to be corporate goals. It is important to recall that participants recognized they often did not have the opportunity to choose whether or not they worked in a morally uninhabitable workplace. For example, participant 3 spoke of nurses being captured in their particular institution because there were no other opportunities nearby for them to practice their specialty. Nurses left to reconcile and continuously navigate morally uninhabitable workplaces increasingly experienced moral distress.

### **Competing Truth Claims and Disqualified Knowledge**

Management prioritized change initiatives that were visible and tangible, as reflected in the kinds of changes implemented: intravenous pumps, electronic documentation, medication cabinets and Lean programs. Nurses' priorities, such as gaining back ample time to provide quality care, are not visible or tangible entities, which contributed to their low value in the organization. For instance, participant 9 recalled her unit being equipped with a brand new infant bilirubin bed, but not being properly staffed to adequately support an infant's mother to successfully breastfeed.

During interviews, participants emphasized relational aspects of care that in their view were compromised during change initiatives such as establishing and maintaining trust and therapeutic relationships. These aspects of care are difficult or impossible to measure and often omitted from organizational change discourses due to their subjective and abstract nature (Campbell, 2000; Weiner et al., 2008). In comparison, participants identified leadership concerns as focusing on concrete matters such as managing bed flow, decreasing costs, implementing technologies and monitoring performance indicators, all of which are easily quantifiable outcome measures (Dickson, 2009; Elrod & Tippett, 2002; Steiger, 2009; Weiner et al., 2008). Dickson (2009) notes that efficiency and productivity are not accurate measures of quality in health care delivery; the same warning participants relayed in their interviews. For instance, solutions in the form of multiple updates to the electronic documentation system, while easily measured, did not decrease the amount of time required of participants to document their care and contributed to the loss of even more time at the bedside. Nurses did not measure their experiences of loss as a specific number of minutes per day at the bedside, but rather in relational terms, namely as loss of human connection with patients, families and colleagues. These findings are consistent with Toll (2012), who noted nurses described loss in terms of human connection as they related to specific change initiatives. The register used by nurses to

articulate their voice is based on elements that leadership does not readily recognize and is not part of the dominant managerial discourses that govern their practices (Scherer, 2009).

Managerialism is understood by critical management scholars as the rise of a managerialist ideology that has legitimized management as a:

Social practice, and a position of status supported by institutional and social norms that give managers the right to hire, fire, give orders, control and evaluate the performance of others in the interest of efficiency, productivity, profit or providing a service (Cunliffe, 2009, p. 17).

Additionally, managerialism is understood as “a kind of systemic logic, a set of routine practices, and an ideology...a way of doing and being in organizations which has the ultimate goal of enhancing efficiency through control” (Deetz, 1992, p. 22). Increasing managerialism in health care created a narrower discourse of patient care than what participants articulated as patient care, because it focuses on service delivery as opposed to care delivery. Managerialism informed understandings of care include services that can be managed, as opposed to caring as a relational means of fostering human connection and healing (Hau, 2004; Traynor, 2012). The concept of care also emerged in nurses’ discourses about their relationships with the organization, insofar as participants described feeling as though the organization did not care about nurses. Here too, it may be that the core conceptual understanding of caring differed between many nurses and administrators. Management could well perceive that caring for nurses was enacted by providing them with new equipment intended to better support their work, or implementing Lean processes to give nurses a voice at the unit level. Nurse participants interpreted these acts as caring for the institution and its image/reputation as opposed to caring for nurses per se.

Nurses described how increasing administrative and corporate duties compromised their ability to provide care. Similar nursing perspectives were noted by Traynor (2012):

“Administrative duties were seen as the antithesis to care delivery and were frequently identified

as a cause of time constraints” (p. 147). On the other hand, managers may understand that engaging in administrative and corporate work constitutes a legitimate form of patient care. Results from this dissertation suggest management positioned administrative duties as an increasingly relevant, necessary and inevitable component of nurses’ duties of care. This finding is consistent with the scholarship of Rankin and Campbell (2006), who found that the infiltration of managerialist inspired ideas, such as corporatization, into nursing practice increases the demands on contemporary frontline nurses.

Critical management scholars suggest that managerialist thinking value certain kinds of knowledge and exclude others (Alvesson et al., 2009), which has unique implications in complex organizations such as HCOs (Kitchener & Thomas, 2016; Learmonth, 2003). If voice is a reflection of an individual’s truths claims and the articulation of their unique body of knowledge, when aspects of nurses’ voices are not heard their professional knowledge is not validated and is set at the margins of organizational discourses. This places nurses in positions where they feel powerless over their day-to-day practice and powerless to use their nursing knowledge to decrease the impact of multiple change initiatives on patients, families and care providers. Furthermore, it has created a need for nurses to speak more in line with the dominant discourses grounded in managerial ideas and values in order to have a stronger, more strategic influence. In doing so, nurses participate in the legitimization and perpetuation of such monolithic discourse. As managerial practices, discourses and ideologies are normalized in HCOs, questions or critiques are rendered invisible (McMillan, 2016) and nurses appear to accept the effects on their practice.

What happens when we turn a critical gaze to this normalization process and question the expectation that nursing knowledge must align with managerialism to gain legitimacy, specifically as it relates to restructuring and organizational change? Lindsay (2003) expresses that such critique creates a powerful counter narrative: “could we take nurses’ responses to restructuring as a measure of the situation, instead of strategizing how to change nurses so they

will adapt and cope?" (p. 17). Posing such a question allows for the further exploration of certain forms of nursing knowledge, including experiential knowledge, that have been marginalized and effectively disqualified in relation to other, more predominant managerial discourses.

HCOs have discursive practices that create spoken and unspoken rules that allow certain statements, reflective of specific truth claims, to be made, while effectively disqualifying others. Foucault (1979) described disqualified knowledge as that which may hold true for many but, because that knowledge may not always support dominant discourses, becomes excluded from important decisions about how organizations operate. Data generated from this study supports the suggestion that some forms of nursing knowledge that held true for many nurses but did not support dominant managerial discourses regarding organizational change were excluded from decision-making and implementation processes. Critical management scholars attest that mainstream organizational change discourses govern knowledge development and individuals within organizations (Alvesson & Deetz 2000; Huber et al. 1993; Thomas 2009). Analyzing the history of organizational change reveals a "history of conflicting interests, alignments, and negotiations" (Bacharach & Lawler, 1998, p. 70) alongside competing narratives where certain discourses have won legitimization and others have remained obscure (Buchanan & Dawson, 2007).

The literature review noted that dominant organizational change discourses have legitimized knowledge that is standardized and scientifically driven: "standardized and scientifically oriented knowledge about health-care creates new ways of rationalizing and broadening the reach of systems to manage professional practice" (McKinlay & Starkey, 1998, p. 9). When such knowledge becomes dominant, the methods of evaluating and measuring change outcomes in health care focus more on system outcomes and less on the impact of change on individuals. Participants' narratives illustrate organizational change as increasingly governing and standardizing their practice whilst failing to acknowledge the toll of changes on nurses' well being, professional identity and the integrity and safety of patient care. When there

is heavy focus on systems, the many individuals that make up these systems can be overlooked or treated as an undetermined mass of subjects-objects. An example of this described by participants in their practice was the belief that “a nurse is a nurse is a nurse” and in light of this mentality participants felt they were being used as “just a body, as long as the space is filled with the body that’s fine” (participant 6, line 205). The data in this study suggests that certain aspects of nurses’ experiences during rapid and continuous change, such as the loss of specialization in their practice, were minimized amidst the drive for efficiency and cost-reducing measures. Such omissions effectively downplay both the complexity of change initiatives and the associated experiences of organizational members, findings supported by the critical management scholarship community (Bazzoli et al., 2004; Buchanan & Dawson, 2007; Weiner, et al., 2008).

Alternatively, when attention is given to the complexity of organizational change and individuals’ subsequent experiences, the impact of change becomes more than quantifiable fiscal gains or losses. Reliance on standardized change frameworks in health care; such as Lean minimize the recognition of multiple yet distinct organizational cultures within health care institutions (Beil-Hildebrand, 2005). This becomes problematic as a variety of cultures within HCOs make change implementation unique and often challenging (Beil-Hildebrand, 2005). This was noted in the data regarding Lean implementation processes and increasing standardization practices throughout the organization. Heavy reliance on business management frameworks fails to recognize individuals and their unique experiences of change within organizational cultures, and such omissions contribute to the high rates of change failure noted in HCOs (Dickson et al., 2012). Several industries, including finance, manufacturing and informational technology (Herold et al., 2007), have identified this causal relationship.

This study’s findings suggest that, from participants’ perspectives, multiple change initiatives had failed not only patients and families, but also frontline health care providers. The human experience of organizational change in health care reveals an alternative paradigm that

helps examine the nature of knowledge and its importance in better understanding organizational phenomena. This shift in philosophy challenges taken-for-granted assumptions that have informed much organizational change research and, in doing so, provides opportunity to explore alternative concepts in relation to organizational change such as the concept of disqualified knowledge.

In the development of dominant organizational change discourses, nursing knowledge has been subordinated in ways where nurses must “revise their own judgment in line with managerial knowledge” (Rankin & Campbell, 2006, p. 66). Certain forms of nursing knowledge may continue to be disqualified during the ongoing normalization of rapid and continuous organizational change in HCOs. In addition to this study’s findings, other researchers have documented nurses’ feelings of voicelessness and powerlessness amidst organizational change wherein nurses felt their voices, and thus their knowledge was not valued (Korunka, et al., 1997; McGibbon et al., 2010). These studies collectively contribute to a better understanding of the disqualification of nursing knowledge during periods of organizational change.

Foucault (1979) recognized the potential for knowledge to become disqualified under certain conditions based on its ranking as “low-ranking knowledge” (p. 21). Knowledge becomes low ranking when dominant discourses deem it so. As previously described, dominant organizational change research is grounded in managerial perspectives that often underrepresent other organizational members (Alvesson & Deetz, 1996, 2000; Jones, 2009). Relying on dominant discourses for knowledge development disqualifies other forms of knowledge, making desirable and acceptable certain ideas about organizational members and their relationships to organizational concepts. This stifles organizational knowledge development because dominant discourses and knowledge link certain concepts to certain phenomena, compromising the capacity to explore alternative constructs and explanations for organizational processes. Heavy reliance on nurse resistance to explain change failure is an example of this simplistic conceptual linking discussed in this study.

Current mainstream understandings of organizational change have created distinctive and restrictive binaries. Binaries do not readily facilitate expanding the use of concepts beyond current understandings to explore newer situations or phenomena that remain poorly or narrowly understood, ideas reflecting conceptual expansion, a term coined by Tsoukas (2009). Conceptual expansion seeks alternative ways of knowing and seeks underrepresented perspectives to learn from the novelty and unsettledness they create (Tsoukas, 2009). Conceptual expansion (re)explores concepts that may have been disqualified by dominant discourses. According to Foucault (1979), it is only through the re-emergence of disqualified knowledge that critique may be used as a form of knowledge construction; where alternative concepts may emerge that describe phenomena from the perspectives of the underrepresented. Critique is imperative in advancing organizational knowledge as it often comes from a place that willfully seeks to better serve underrepresented members of organizations (Tyrell, 1998), who offer alternative understandings of organizational phenomena. Conceptual expansion is opposed to what Tsoukas (2009) describes as conceptual closure, which is fueled by degenerative dialogue reflecting only one of many perspectives. Findings from this study suggest that change fatigue is an emergent concept that has surfaced as a result of conceptual expansion. Change fatigue represents experiential nursing knowledge that has been disqualified from dominant organizational change discourses.

When organizational change fails, leadership predominately blames nurse resistance (Elrod & Tippett, 2002), reflecting certain assumptions about the nature of causation (McMillan & Perron, 2013). The concept of nurse resistance has gained wide acceptance in mainstream managerial literature and subsequent organizational change discourses (Buchanan et al., 2005; Elrod & Tippett, 2002). Nurse resistance as a causal explanation exemplifies the effects of normalizing techniques within organizations. Change is desirable, change failure is undesirable. Correct nursing behavior should support change initiatives; incorrect nursing behavior opposes change. Mutually exclusive categories of correct-incorrect and desirable-undesirable are

described as problematic by McKinlay and Starkey (1998) because “Restrictive binary divisions take idealized taxonomies as the starting point for empirical research” (p. 10). Binary divisions hinder the theorizing and research required to foster conceptual expansion and bring to light disqualified knowledge. For example, analyzing rapid and continuous change from different philosophical perspectives, as this study has done, yields knowledge that reflects the existence of alternative phenomena beyond resistance such as change fatigue. The concept of change fatigue appears to more accurately describe nurses’ knowledge claims regarding rapid and continuous organizational change.

The data provided conceptual clarity regarding the emergent concept of change fatigue. Conceptual clarity is an important initial step in clearly articulating nursing knowledge and associated truth claims (McEwan & Wills, 2014). For example, the data suggests most participants became apathetic towards, and disengaged from, multiple change initiatives. Participants noted they just needed to “keep going with the flow because you just have to get your work done” (participant 13, line 410) and nurses had to do their best to “make it work” (participant 4; line 229; participant 8, line 600; participant 10, line 573). Such frame of mind may reflect aspects of change fatigue (Allan et al., 2014; Bernerth et al., 2011; Brown & Cregan, 2008; Buchanan et al., 2005; MacIntosh et al., 2007; Torppa & Smith, 2011; Wall, 2010).

The literature review undertaken for this doctoral study theorized that change fatigue resulted from nurses’ experiences with immediate and current change processes (Bernerth et al., 2011). Other authors thought that resistant behaviors tend to be a result of a long history of repeated organizational failures (Abraham, 2000; Bernerth et al., 2011). In the literature review, I suggested that based upon these assumptions change fatigue may be easier to address and subsequently alleviate, as the associated behaviors do not appear to be engrained like those associated with resistance to change. However, the data suggests that the experience of change fatigue is embedded within the historical context of an individual’s experiences within an organization. The apathy and disengagement that nurses experienced were directly related to

repeated negative experiences of change. With this interpretation of the data in mind, it may be more complicated to address the experience of change fatigue than originally thought, because according to participants, those repeated negative experiences fostered distrust, which they believed would take years to rebuild within an organization. This important clarification helps further explore some of nurses truth claims generated from organizational research.

Literature suggests that the experience of change fatigue may cause increased employee absenteeism during periods of organizational change (Hansson et al., 2008). The data from this study supports this assertion. Nurses' well-being declined as a result of rapid and continuous changes and participants reported higher levels of absenteeism and higher rates of nurses on prolonged sick leave. Nurses indicated their self-care was repeatedly sacrificed in order to be with patients due to increased demands during periods of rapid and continuous change. Further, the sense that there was 'no end in sight' to continuous change implementation contributed to nurses' apathy towards change and disengagement from future organizational change initiatives.

Organizations that use change management discourses that perpetuate conceptual closure foster an inherent silencing of other ways of knowing within organizations. This may be true for the concept of change fatigue. From a critical lens it can be argued that through relations of institutional power/knowledge the experience of change fatigue has been normalized and has become a taken-for-granted phenomenon inherent in organizational change. This has been done through the dominant discourses that portray nurses' responses to change as acts of resistant. Reflecting upon the definition of change fatigue suggests there are striking differences that do not reflect resistance.

The utilization of a conceptual expansion lens in the analysis of the data collected for this study revealed the complexity of organizational life, and facilitated the exploration of what Linstead et al. (2014) call the 'dark side' of organizational life. As previously noted, studying the dark side of organizational life reflects a shift in interests from systems to the inner workings of

the people within systems (Linstead et al., 2014). When focus shifts from standardized and scientifically oriented knowledge (McKinlay & Starkey, 1998) to knowledge that is politically, morally and ethically aware, there is opportunity to explore the darker side of organizations where concepts such as disqualified knowledge, voice, power and parrhesia (Foucault, 1980) exist. It is within the exploration of these concepts that one may find the discourses representative of the underrepresented.

Data analyzed in this study reflects the underrepresented discourses of nurses', offering profound insight into complexities of organizational change that has illuminated the dark side of organizations. The knowledge possessed by those underrepresented may challenge individuals to look beyond the distinctive and restrictive binaries that shape current understandings of much organizational phenomena (McKinlay & Starkey 1998), for example the sole usage of change resistance to understand nurses' experiences of organizational change. Moreover, in my view, perspectives of the underrepresented can contribute to the construction of a timely and necessary counter-narrative. In this study, certain regimes of truth regarding change in HCOs had been established that were often at odds with what nurses articulated as their truths, in particular about the nature of their work and the delivery of patient care.

Dominant discourses of truth discussed by participants reflected a managerialist conceptualization of health care driven by efficiency and cost-containment. Alternatively, nurses' claims to truth in this study were embedded within a relational ethic of care that prioritized human connection and relationship building. The knowledge was most often disqualified in participants' narratives appeared to be discourses that lobbied for conditions conducive to what nurses constructed as caring. The dismissal of such discourses created work environments similar to what Nortvedt, Hem and Skirbekk (2011) exercise concern and caution over: "If the conditions of caring for specific patients are constantly impoverished, the basic structure of professional knowledge, as well as...the protection of patients, is jeopardized." (p. 199). Lindsay's (2001) doctoral work conveyed similar concerns regarding the exclusion of nursing

knowledge in the provision of care, “Patient care needs to be about patients, with enough caregivers to give care that includes the knowledge of nursing” (p. 140). Nurses in this study believed that their knowledge and truth claims were not recognized as valid when that knowledge contradicted managerial values. Participants perceived that management and leadership failed to recognize nurses as knowledge makers.

Participants derived knowledge by thinking critically, an expected skill of nurses’ professional practice (College of Nurses of Ontario, 2014, 2015). This skill, however, was increasingly limited in participants evolving work structure. Participants described contradictory messages from management within their workplace, which they seemed to attribute to two distinct, mutually exclusive, bodies of knowledge: nursing and management/leadership. It is important to note that there were nurses who agree with certain aspects of managerial discourse. For example, within managerialism patient care and patient safety are important too; what differs is the ways in which care and safety are constructed and enacted. Analyzing these apparent dichotomies allows for exploration of the power/knowledge relationships that underpin the differences and similarities of these seemingly opposed and binary discourses. It is plausible that management may well identify contradictions within nursing as it relates to rapid and continuous change. For example, nurses asked for education regarding specific change initiatives, but said that the education provided was not effective and did not adequately prepare nurses to manage changes. In the same vein, management created daily team meetings for nurses to air their concerns, but some nurses actively avoided attending these. These are but a few examples to demonstrate that although much of nurses’ narratives described opposing and dichotomous relationships between nursing and management, conclusions must be critically examined in light of the way these views mobilize similar concepts to gain epistemic legitimacy.

When confronted with contradictory messages, nurses recognized that the knowledge they constructed and used in and around caring was at odds with managerial imperatives. Most notably participants described the paradox of doing more with less, which nurses interpreted as

“being asked to do the impossible” (participant 9, line 1663). Some authors describe that health care environments with this doctrine set both systems and nurses up to fail:

The health care system is so destabilized by extreme workload and by systems designed for cost control [that] downsizing and a sense of threat became the foreground... and despite best efforts, the nurse accepts the untenable premise that she must let the system fail (Benner, Hooper-Kyriakidis & Stannard, 1999, p. 465).

This sentiment was echoed by participants who believed that reduction of services with increased expectations of nurse performance were unachievable. Amidst these contradictions there is remarkable tension. On the one hand, the mounting possibility of multiple change initiatives in health care described in managerial scholarship (Andreasson, Eriksson & Dellve, 2016; Dlugacz, Restifo & Greenwood, 2004; Leebov, 2002) and, on the other hand, the mounting impossibilities discussed by nurse participants. Mainstream managerial literature invariably suggests that managed care, standardization and efficiency driven models of health care delivery such as Lean, will fix the woes of the system (Aij & Lohman, 2016; Bukowski, 2014; Dahlgaard, Pettersen & Dahlgaard-Park, 2016; Lighter, 2011; Platcheck & Kim, 2012). Conversely, participants identified how the aforementioned change initiatives negatively impact nursing and patient care delivery, suggesting that the system would work much better if nurses were given back autonomy over their practice, were relied upon for the use of their knowledge, and were given the time required to provide quality and safe patient care. There are opposing thoughts between dominant health care literature (Aij & Lohman, 2016; Bukowski, 2014; Dahlgaard et al., 2016; Lighter, 2011; Platcheck & Kim, 2012) and nurses' narratives regarding the current conditions of contemporary health care environments. This opposing thought is captured in O'Brien-Pallas and Baumann's (1992) metaphor: "Are nurses and the environments in which they work in the same canoe but paddling in opposite directions?" (p. 15). Nurses are tasked to work within these tensions in ways that attempt to minimize the impact of rapidly changing HCOs on patients. This was evident in the data when participants described at length

the ways they structured, restructured, evaluated, and re-evaluated multiple ways to provide nursing care amidst these often-conflicting discourses. Often to mitigate tensions and to provide what they understood as quality care, participants described engaging in resistive, transgressive and self-sacrificial behaviors.

### **Resistance, Transgression and Self-sacrifice**

Some participants covertly went about using their knowledge in decision-making and patient care delivery. This was done either by re-framing their narrative to fit into managerial discourses or by exercising resistance and transgression to take back some level of power over their practice. Unlike works cited in the literature review describing the need for, and positive contribution of, resistance to change efforts (Ford et al., 2008; Thomas et al., 2011; Umiker, 1997), data from this study suggests that acts of nurse resistance ranging from questioning the changes to not following standardized work processes was seen by management as negative and disruptive behavior. Participants recalled being told not to question change, and encountered negativity from management when they did. Participants also recounted being told by management that nursing concerns arose simply because nurses did not like change and could not adapt. Such assumptions risk perpetuating harmful stereotypes against nurses and their handling of change. Challenges associated with organizational change point to an epistemic issue when we shift our focus away from purportedly unaccommodating and intractable individuals, to the systemic mechanisms that determine who is a valid knower and who is not within the organization (Perron & Rudge, 2015).

The data from this study illustrates that some participants developed strategies to enact aspects of nursing work that appeared to be undervalued by management and leadership. These nurses described how certain actions, informed by nursing knowledge and ideologies of care, were deemed by management as resistant and transgressive. These actions included: retroactively charting nursing care beyond the window of time outlined in the organization's policy, visually verifying medications from the medication cabinet instead of scanning them, and

not attending the daily unit meeting. The reasons given by participants for engaging in these activities was to free up time to spend at the bedside with patients and their families. Nurses also engaged in self-sacrifice practices to create more time in their day to be at the bedside. Participants recognized that since the implementation of multiple change initiatives, there had been a drastic increase in the frequency of skipped meal breaks, staying late to retroactively document care delivery, and coming in earlier for shift handover to ensure the construction of a complete patient story. Data showed that repeated self-sacrifice behaviors negatively impacted nurses' well being, an issue previously raised by Rankin and Campbell (2006) and Bazzoli et al. (2004).

Nurses and members of the leadership team largely normalized the multiple elements of self-sacrifice described in the data. Participants recalled being told the additional time required to complete their work was simply part of the change process, and the time it took to complete their work would eventually return to what it had previously been. However, when it did not, nurses continued to miss their breaks. Over a period of months it came to the point where not taking breaks was a normalized aspect of their work. This links back directly to the idea that nurses said they "can do no more" (participant 9, line 563), but they continued to do more. This created a paradox that was not convincing to leaders who heard nurses voice anger, frustration and the inability to provide adequate nursing care due to multiple change initiatives, yet saw nurses continue to navigate and manage care provision within the organization.

Literature reports that individuals in any organization require time to adjust and adapt to change, as change restructures how individuals must carry out their work (Campbell, 2000; Kotter 1995; Kuokkanen et al., 2007). Yet the data in this study makes evident that time to adjust and adapt was seemingly not taken into account in nurses' workloads. Requests for overtime were rejected and blame was placed on nurses for not organizing their patient assignments properly. Participants noted they brought these concerns forward to managers, other nursing leadership and even to administrative executives, but described such concerns as

“falling on deaf ears” (participant 3, line 370). The data highlighted multiple ways in which participants’ concerns were brushed off or alternatively rationalized and normalized by managers. This finding is consistent with Korunka et al. (1997) and McGibbon et al. (2010) who reported similar feelings of voicelessness and devaluing during organizational change. Participants recounted many instances of dismissal and situated these as part of the organizational culture. Participants felt that over time, their value within the institution had declined as the focus on efficiency and cost saving increased. Rodney’s (1997) dissertation work supports that “a number of dominant sociopolitical ideologies seemed to be embedded in the organizational culture, including the devaluing of nurses’ work” (p. 363).

Nurses became an object of blame when the ways in which they practiced did not fit within what was perceived as a managerial driven organization. This study suggests that what is needed alternatively is the validation of nursing knowledge and its use to better understand the complexities of care. This could be achieved by taking nurses’ predictions seriously regarding inadequate, and at times unsafe technology. This contributes to a counter narrative that turns a critical gaze towards the knowledge, values and practices managerialism creates and perpetuates in HCOs. It provides new knowledge that represents the multiple others outside of management and leadership who work within health care, including nurses. Attention to the construction of counter narratives that move blame and scrutiny for failing health care systems away from nurses is supported by the Canadian Nursing Advisory Board, who in its 2002 recommendations to Health Canada, reported that, “What is apparent in all this [research] work is the need not to repair nursing, but rather to renew and repair the work environments in which nurses practice” (p. 25). Repairing the environments in which nurses’ practice requires critical reflection on three important things: 1. The (in)visibility of nursing knowledge and voice in organizational decision-making; 2. Knowledge production and utilization in HCOs, and 3. A critical analysis of both individual and organizational moral commitments in contemporary HCOs. I have discussed the (in)visibility of nursing knowledge and voice in organizational

change decision-making. I now critically examine knowledge production and utilization in HCOs, followed by an examination of moral practices of individuals and organizations as they relate to, and are impacted by, rapid and continuous organizational change.

The data suggests governing knowledge production within nurses' workplace created a dichotomy between what nurses wanted to know versus what the organization believed nurses should know. This dichotomy worked to disqualify what nurses deemed as valid and important knowledge. The kinds of knowledge development facilitated by the organization were most often in relationship to organizational change implementation and corporate related agendas, as opposed to specific or specialized skillset training. Participants described wanting to advance their own professional knowledge and skillsets unique to their chosen practice area through professional development days and specialty certifications, such as ALS (Advanced Life Support) courses. Yet, participants stated the funding for such professional development training had been frozen in light of recent budget cuts, even though such certifications often were requirements of their job. Similar findings are reported by Gray (2008), Dean (2011) and Gordon (2006) who note nurses' training budgets are sacrificed early on when budget cuts are implemented.

The data suggests that management was increasingly governing nursing practice in ways that participants believed to be deskilling nurses. The hospital, for example, was widely standardizing many nursing activities and compartmentalizing certain aspects of care. Nurses described having less autonomy over their practice and noted their workflow and processes were increasingly governed. Increasing governance over nursing practice and lack of institutional support for skill and knowledge development specific to their chosen specialty are what led nurses to the conclusion that their unique body of knowledge was not highly regarded because the mentality within the organization had shifted to "a nurse is a nurse is a nurse". The "nurse is a nurse is a nurse" belief has been well documented in the literature, dating back to the mid 1960s where it was described as detrimental because it fostered decreased nurse

competency, medical errors, poor patient outcomes and low nurse work satisfaction (Carpenito, 1995; Eicher, Marquard, & Aebi, 2006; Marsh & Willcocks, 1965; Murphy, 1990). What is unique about the data presented in this study is that in addition to the aforementioned detrimental factors, when the “nurse is a nurse is a nurse” mentality is combined with a growing focus on efficiency and budget (system), rather than nurses and patients (people), the resultant restructuring of nursing work altered nurses’ perceptions of themselves and others in ways that profoundly impacted their identity construction.

### **The Reconstruction of Nursing Work: Perceptions of Technology, Self and Other**

A “nurse is a nurse is a nurse” mentality was described in the data in relation to an increasingly prominent culture of floating. Participants discussed how nurses were floated from their own unit without notice or training to other specialties to meet hospital wide staffing shortages. It appears nurses were used as a means to a end to meet organizational needs. This process can be described as “standing-reserve”, a Heideggerian term used to explore Being and being, and the ways in which multiple technologies have enframed (Gestell) humans in ways that have de-humanized being. Heidegger understood Enframing as follows:

Enframing means the gathering together of that setting upon that sets upon man, i.e. challenges him forth, to reveal the actual, in the mode of ordering, as standing-reserve. Enframing means the way of revealing that holds sway in the essence of modern technology and that is itself nothing technological (p. 69).

Heidegger argued that it is not the physical technologies that have worked to de-humanize being, but rather the human mindset that frames the use of technology. As such, humans become tools to be used to advance science and technology. Heidegger expressed concern that people in the modern world were thinking about themselves, others and nature as things to be used, and ought to be used as efficiently as possible. Similarly, participants observed that

they were being used as means to an end, as interchangeable pieces within the hospital so as to satisfy hospital wide staffing shortages.

When efficiency and technological changes began to drive how participants felt they ought to deliver care, two important things happened. Nurses were used as means to fill staffing needs and to maximize hospital efficiency (efficient use of paid nursing hours). Participants throughout the institution also noted deskilling. Deskilling impacted nursing practice in the following ways: nurses felt less autonomous, increasingly governed and standardized, and increasingly reliant on technology. Ways in which nurses described their relationships with technology reflected a master-slave relationship; nurses at times felt enslaved by technology.

Domination forms the basis of the master-slave relationship, the existence of which is relationally dependent on others (Rollins, 2007). For Nietzsche (1969) specifically, the master acts as the initiator, and the slave as a reactor, who is acted upon. Participants felt that technology had control over, and acted upon them and their work. Some participants attempted to manipulate technology in ways that decreased the amount of time required to manage it – for example, manually verifying medications dispensed from the medication cabinet. Nietzsche (1969) referred to such acts as the creativity of slaves that lies within their reactions to their master, as opposed to these actions being narrowly understood as resistive and transgressive. Nietzsche (1969) also theorized that slaves felt resentment. The data clearly shows that participants resented technology for being time consuming and causing frustration and stress in their practice: “this bloody computer on wheels, that you want to kick” (participant 5, line 1062). Resentment is understood as reactionary to a hurt or injury (Frings, 1965), which for nurses may have resulted in large part from the organization’s perceived prioritization of technological knowledge over nursing knowledge.

The slave morality, as described by Nietzsche (1969), is grounded in the concept of blame, which helps understand the moral challenges nurses experienced in their relationships to technology. Participants blamed technology for much of the guilt they experienced when they

described spending more time managing technology than caring for patients. They believed that without the interference, inefficiencies and time demands of technology, nurses would be able to dedicate more time to direct nursing care activities. Manipulating technology was not seen as a caring act by participants, but rather as distractions from caring acts. An ambiguous relationship between technology and participants is noted in the data. Technology was portrayed as an adversary, something that got in the way of nurses' work, something they had to "babysit" (participant 5, line 1061), and something that created patient safety issues. Yet, the patient safety literature and prevalence of critical events associated with medication administration has led to regulations and accreditation standards regarding the need for change in HCOs, predominantly the implementation of technologies to enhance patient safety (Curtin & Simpson, 2002; Emanuel et al., 2017; Makic, 2015; RNAO, n.d; Tso-Ying, Li-Tseng & Yeh, 2017). Nonetheless, technology was positioned as something that ought to be heavily problematized.

There was no mention in the data of how technology supported nursing work, even though nurses used technology consistently throughout their workdays. For example, a stethoscope, a bedpan, guard rails on beds, monitors, even fax machines, telephones, and computers to access lab results, are all pieces of technology nurses frequently use when caring for patients. Participants exclusively referred to technology when they were flagging problems; as a result, much of the technology in nurses' work appeared to be taken-for-granted until it broke down. These nurses' accounts are consistent with nurses' perceptions of technology noted in the literature, which primarily reflect a tense relationship that mediates caring in negative ways (Brundt, 1985; Marck, 2000; Mullen, 2002; O'Keefe-McCarthy, 2009; Orlikowski, 2010; Piscotty, Kalisch & Gracey-Thomas, 2015; Yeo, 2014). These perceptions are most often associated when nurses feel technology is given power over nursing practice (Barnard, 1997; Sandelowski, 1999). Nurse's negative perceptions coincide with critical management scholars' perspectives on the impacts of technology on individuals' organizational lives (Alvesson &

Willmott, 2002, 2012; Grey & Fournier, 2000; Law, 1991; Peltonen, 2016; Ritzer, 1993; Spicer, 2005).

Critical management scholars note that technology negatively impacts workers in the following ways: it reinforces subordinate relationships to management (Alvesson & Willmott, 2012; Braverman, 1974; Spicer, 2005), deskills workers (Knights & Willmott, 1990), perpetuates standardization and division of labor (Ritzer, 1993) and negatively alters ways in which communication occurs in organizations (Alvesson & Willmott, 2012; Drake, Yuthas & Dillard, 2000). However, both nurses' and critical management scholars perceptions of technology remain marginalized compared to larger health informatics discourses, which most often suggest that nurses should accept technology as an "adjunct" (Adams, 1986, p. 32) or "resource to be used" (Barnard, 1997, p. 127) in order to enhance care delivery (Agius, 2012; Ashworth, 1987; Baker, Bokovoy & Matchett, 2005; Barton, 2010; Cliff, 2012; Patton, 2012) and patient outcomes (Mullins et al., 2011; Patton, 2012; Rosenthal, 2005).

Nurses' relationships to technology have been predominantly researched in critical care areas where managing technology has been discussed as a unique component of critical care nursing practice (Alasad, 2002; Almerud 2008; Crocker & Timmons, 2009). Nurses' relationships to technology have also been described in the literature from patient perspectives, where patients have noted that nurses were vigilant while managing technologies, but in doing so paid "less attention to patients' stories and experiences" (Almerud, 2008, p. 39). The data from this doctoral study echoes Almerud's work. Participants stated they paid less attention to patients, and more attention to managing multiple technologies across all acute, inpatient areas of practice. In light of contemporary increases in technological implementation and reliance across a range of nursing perspectives, this conversation would best be served by examining practice settings beyond critical care. Some of the assertions made by critical care researchers can be more broadly generalized. For example, Crocker and Timmins (2009) suggest that critical care technology ought to be reconfigured into technology that facilitates nursing work

and does not divert needless attention away from patients. Doing so in all areas of nursing practice could effectively contribute to the reversal of the master-slave relationship described by participants in this doctoral study.

An important step in reversing this master-slave relationship is recognizing that technology is not a neutral influence on nursing practice (Barnard, 2007). Its perceived power comes from a broad range of discourses, beliefs, assumptions and practices (sociocultural, scientific, tied to market interests, etc.) that pervade HCOs and therefore local administrative and bureaucratic processes. In this regard, technology is a political entity that creates meaning, influences relationships and shapes specific subject (nurse, patient) positions within an organization, thus impacting matters of identity and agency. Nursing scholar Sandelowski (2000) drew similar conclusions about technology in health care, stating “the ontological, conceptual, and representational boundaries between nurse/human/subject and machine/not-human/object, and between true and technical nursing, became increasingly blurred” (2000, p. 2). The notion of technology as neutral may be challenged when, for example, examining smart pump technology, which many participants spoke of. The self-monitoring capabilities of smart pumps can block nursing actions through the recognition and processing of data (e.g., values inputted by the nurse) and the possible overriding of the nurse’s command, whereby previous version of that technology (e.g., IV [intravenous] administration via drip or gravity) did not. From a CMS perspective, the lack of neutrality comes from the oppressive features of technology (Alvesson & Deetz, 2000; Alvesson & Willmott, 2012; Braverman, 1974; Spicer, 2005; Thomas, 2009). These scholars note that oppressive structures lie outside specific pieces of technology and are a reflection of administrative and bureaucratic structures (Alvesson & Deetz, 2000; Alvesson & Willmott, 2012; Braverman, 1974; Spicer, 2005; Thomas, 2009). This assertion suggests that nurses’ adversarial relationships with technology reflect equally challenging adversarial relationships with hospital leadership, as leadership is responsible for enabling the technological power over nursing work. Some participants alluded to such an understanding

when they suggested that those (in leadership) who purchased various technologies did so in ways that disregarded nursing knowledge. This may be a limited view of the power of technology. While technology can be a negative entity in nurses' work lives, it also supports nursing practice and thus at times is a positive and productive element that supports patient outcomes.

Locsin (2001) articulates the importance of finding ways nurses may construct a positive relationship with technology – a relationship that enhances the fundamental principles guiding the discipline of nursing, most notably the capacity to care. Locsin supports a less adversarial and more complementary view of the relationship between the nurse and technology. Heskins (1997) found that technology facilitates advanced healing, and at times freed up nurses time by continuously monitoring vital signs and the ease of electronically inputting associated data. Heskins highlighted that such positive aspects of technology are sparse in literature. Hill (2013) argues that “Only through a connection between technology and caring can the true humaneness of relationship building occur” (p. 2586). These works are of paramount importance at a time when technology in health care is advancing at unprecedented rates in order to meet increasingly complex patient needs (Korhonen, Nordman & Eriksson, 2015; Locsin, 2017). As technology advances, the priority must always remain on the care of the patient (Hill, 2013). Technology and caring must co-exist; in order to be seen in a positive light, technology must enable nurses to care. Perhaps this understanding can pave the way toward reversing the master-slave relationship by further exploring what technology reveals about the discourses and practices that shape nursing practice. This notion may be further understood by returning to Heidegger's works on technology.

In the text, *The Question Concerning Technology*, Heidegger (1977) explored how we currently frame technology and also inquired how we could effectively have a “free relationship” with it. How then can nurses have a “free-relationship” with technology in their practice, as opposed to a master-slave relationship? Nurses provided multiple suggestions and commentary

on their practice environment that I believe move towards the “free relationship” Heidegger challenged us to imagine. Collectively, the suggestions and commentary provided by participants articulated that health care’s orientation to technology must change. Technology’s place in the health care hierarchy must shift; it cannot be placed above the knowledge of health care professionals. Nurses described their relationship with technology as one that offered multiple revelations about contemporary health care and nursing practice. For Heidegger, the purpose of technology is to reveal to humans what we do not know or what has been taken-for-granted. Technology revealed to nurses’ systemic assumptions about the nature of knowledge production and utilization within their workplace. Participants described recognizing that technological knowledge appeared to be given priority over nursing knowledge by those who had decision-making power within HCOs, notably those in leadership.

Participants also understood their relationships with technology as one that confirmed the importance of human connection in their work. The required restructuring of nursing work made it much more difficult for some participants to be mentally present at the bedside whilst managing multiple technologies in patient rooms. In addition, increased amounts of time required to manage technologies outside patient rooms resulted in less time physically spent at the bedside with patients and families. These findings are consistent with some of the scholarly literature critically appraising the integration of technology into health care. Toll (2012) and Gordon (2006) note that human connection is a key aspect of satisfaction among health care workers. Toll (2012) suggests that human connection reinforces a sense of self as healer and carer, which works in restorative ways to prepare health care providers to continue to give. Toll’s (2012) assertions about the relationship between human connection and capacity to give are important, as these findings suggest rapid, continuous, and largely technological changes, deprived nurses of important human connections and seemingly the ability to keep giving. As participant 14 stated: “there’s nothing left the give” (line 666). Toll (2012) further argues human connection in health care is heavily threatened by what she calls the “third player” in nurses

evolving relationships with patients: the computer. This assertion was also found in the data: “there’s always this layer of technology that is supposed to be better than us, between us and the patient” (participant 5, line 732).

Participants noted that the perpetual implementation and exponential use of technology in nursing practice actually made nurses feel more “robotic” (participant 8, line 100) and as though they were “becoming more of a machine” (participant 14, line 146) in their practice. One participant remarked that she often perceived patients as “to do lists” (participant 7, line 286) rather than persons. Another participant noted that technology appeared to create a false sense of security amongst nurses, providing an example that depicted a drastic increase in medication errors immediately following the implementation of a medication cabinet that carried pre-filled, patient specific, medication syringes.

Little nursing scholarship addresses this notion of nurses feeling increasingly like robots as a result of multiple technologies in their practice. Nonetheless, Sandelowski (1998) suggests that the historical “watchful care” (p. 1) of nurses has been altered by medical technologies. She warns nurses they must “revision themselves as critical players in the selling, justification and storying of technologies” (p. 11). The data from this study suggests some nurses may be re-visioning the role of technology in nursing practice in ways that challenge the strong reliance on technology they were witnessing in their practice. What is interesting in this data is the negative connotation associated with the root word “rely” when speaking of technology. Technology was described as “compleety taking over everything” (participant 2, line 557) and the increasingly reliance on technology was framed as a negative aspect of nursing work; something that compromised caring. The connotation was flipped to a positive proposition when another participant described their past and present “reliance” on colleagues, that is, other humans. Nurses recognized that relying on colleagues and mutual problem solving was a fruitful and rewarding aspect of nursing work and enabled caring.

Dissonance between nurses’ positive and negative uses of the word “rely” can be

explained by the ways in which participants separated nursing knowledge from technological knowledge. On multiple occasions nurses described ways in which aspects of their knowledge was at the margins of organizational discourses, seemingly of less and less use in the overall functioning of the hospital. Many change initiatives referred to by participants resulted in nurses feeling deskilled, in that their practice was either being increasingly governed or their knowledge and skills were being replaced by multiple technologies. The shift in practice that saw nurses relying more on technology and less on nursing knowledge and skills was described as a change that “sucks the soul out of nursing” (participant 7, line 289), that was “soul degrading” (participant 9, line 1562), and “soul destroying” (participant 9, line 1568). Perpetual reliance on technology created machine like nurses who felt soulless.

The use of the words “rely”, “robotic” and “soul” are etymologically significant. Rely, is derived from the Latin word, *ligāre*, meaning to bind (Hoad, 2003). In old French *reliagāre* became *relier*, meaning to bind together. Nurses felt bound to colleagues in a positive way, most notably because there appeared to be a reciprocal knowledge exchange with an understanding that both actors, in their ways of being and knowing, were mutually respected and equally valued. This served as an empowering binding together that enhanced patient care. Alternatively, when nurses felt bound to technology, they described technology as having power over them. There was not a reciprocal sharing of knowledge, nursing knowledge was not equally valued, as noted for example, by nurses’ inability to override smart pump technology, an action that was informed by their critical thinking skills. This relationship appears to be strikingly similar to the master-slave relationship previously described. The binding of nurses to technology was described on multiple occasions as detrimental to patient care.

*Robot*, in Gothic translates to orphan, understood as “labor, toil, trouble, distress” (Partridge, 1966, p. 2257). Nurses described multiple ways in which technological changes created workflow processes that were laborious, troublesome and time consuming. This resulted in a significant loss of human connection in their practice, further fostering morally

distressing situations. In Czechoslovak *Robota* means “servitude and forced labor” (Partridge, 1966, p. 2257). Nurses described the power that technology held over their practice and how enslaved they felt to technology, as it had become all encompassing. The word *Robota* appeared in Karel Capek’s 1920’s Czechoslovak publication and play, *Rossum’s Universal Robots*, a science fiction play where a robot was an “artificially manufactured person, mechanically efficient but soulless” (Partridge, 1966, p. 2257). Capek’s representation of *robota* reflects accurately how participants described the implications of technology in their practice. Having to engage with it within a culture of service changed their workplace into a place that pushed efficiency to soul degrading points, where nurses now felt robotic and machine-like in their practice.

Technology within HCOs is playing an increasingly complex role in patient care delivery and the technological impact on the discipline of nursing is far reaching. Technology is not only changing how patients are cared for, it is also re-prioritizing the kinds of knowledge used to inform care delivery. Technological advancements in health care have been discursively depicted as enhancing patient safety (Barton & Makic, 2015; Longhurst & Landa, 2012; Moutzoglou & Kastania, 2013) and increasing efficiency of care delivery (Chaudhry et al., 2006; Grove, 2005; Leung, 2012). The privileged position given to technology in health care is problematic. In keeping with a critical management perspective, this position can be problematized through a closer examination of power dynamics.

Under toning participants’ narratives was the concept of power. Participants did not explicitly say they were rendered powerless by technological inefficiencies, but it was evident in the construction of a collective narrative. Participants felt powerless to comprehensively document their care in a timely manner, powerless to speed up the long wait times and tedious programming requirements for medication cabinets and intravenous pumps. Participants also felt powerless when they raised concerns regarding technological inefficiencies, especially when they were tasked to simply “find a way to make it work” (participant 10, line 573).

The privileging of technology does not give equal attention to these shortcomings, which were more cumbersome than efficient, and in some instances compromised patient safety. Technology was conceptualized anthropomorphically in ways that blurred the lines between human and technology capabilities and ontologies. Such discourse leads to important signifiers that participants used to describe their daily struggles with technology. Nurses described themselves “fighting” (participant 11, line 954) or “wrestling” (participant 5, line 393) with technology, which vividly depict some form of power struggle. Nurses gave technology human-like qualities that included child-like characteristics that prompted a need for nurses to “babysit” (participant 5, line 722) certain pieces of equipment. Anthropomorphism of technology is not unique to nursing discourse but is broadly used in health care, for example, when it is described as being able to care, support and even offer sympathy to patients (Farzanfar, 2006; Locsin, 2001). Nurses become the background instead of the foreground of care in discourses that anthropomorphize technology. Nurses in this study recognized that at times they felt invisible in comparison to technology; technology had taken over their practice and the organization they worked in was both supporting and investing in this movement.

In the technological revolution nurses were experiencing in their workplace their knowledge became less valued and at times not credible in the eyes of influential decision makers. Technology, as discussed in the findings from this study, had the potential to mediate voice. At times, leadership used technology as a currency to manage some of nurses’ voiced concerns (for example buying nurses new pieces of equipment when nurses actually wanted better staffing ratios). There is not enough data to support authoritative arguments that technology is either “good” or “bad” for nurses’ voice, however data does support the claim that there is a significant relationship between technology and the concept of voice.

Current literature offers a small amount of conflicting insight into the potential relationship between technology and voice. One position suggests that technology has empowered patients and has given patient’s a voice in their health care activities through the

use of do it yourself medical devices (Greene, 2016) and can aid in increasing health promotion behaviors (Rose et al., 2010). Alternatively, Lapum et al. (2010) found that technology utilized in the recovery process created an 'authorial voice', making patients feel as though they were "becoming background characters" (p. 754) where they "surrendered agency" (p. 754). There has been little discussion about the potential for a similar relationship between technology and nurses' voices. Manojilovich et al. (2015) suggest that the increasing use of technology changes how nurses communicate, at times hindering their ability to effectively exchange with members of the interdisciplinary team. O'Keefe-McCarthy (2009) asserts that "technology inserts itself between patients and nurses" (p.785) limiting nurses' moral agency. This is a significant finding particularly as it relates to the concept of moral distress. In light of the dearth of literature on the relationship between nurses' voices and technology one could extrapolate that nurses may experience one, or both, of the relationships patients were noted to have with technology, as described above. The narrative from this study's participants suggest that nurses experienced something akin to "becoming background characters" (Lapum, 2010, p. 754) and that the heightened role of technology challenged their identity and agency. Data also highlighted that technology appeared to reveal important truths to nurses about themselves, their voices and their practice in relation to a complex web of organizational discourses and practices.

### **Technology: Revealing a Particular Game of Truth**

Participants recognized that multiple technological changes in their workplace revealed competing healthcare ideologies, described by participant 9 as "care" and "service". Participants described care and service as mutually exclusive; in particular, they reported that, in order to provide service, they must sacrifice care. Technology revealed to nurses that the technical components of their work (the ability to utilize multiple technologies), which often reflected a culture of service, had seemingly taken precedence over, and been given more value than, other aspects of their work that were care oriented, including the building of human connection, constructing a particular 'truth' about the nature of their work. Participants reflected on and

challenged a certain kind of 'truth' about their value in the organization grounded in their technical skills rather than relational skills. In doing so, they used the context of the interview to articulate a counter narrative that can be used to disrupt dominant truth claims. This was done during a confidential interview with the researcher that occurred at a specific time and place, therefore, it is unclear how this disruption might translate outside the confines of the interview space.

Heidegger articulated that the ability to reveal truth is the essence of technology; its role in society is to reveal to humans what they do not know or what has been taken-for-granted. What technology additionally revealed to nurses, was nurses' involvement in what Foucault (1984a) called, a particular game of truth. Nurses' engagement with this game of truth appeared to shape how they interpreted and constructed themselves and their value in rapidly changing HCOs. For Foucault, such games act as a way through "which the being historically constitutes itself as experience, in other words as something that can and must be thought" (Foucault, 1984a: 12-13). Engagement in games of truth resulted in multiple participants recognizing that, oftentimes, their truths about their identity and their work did not coincide with the identity that those responsible for their reliance on technology was (re)constructing for them in practice. Participants observed that such a (re)construction of nursing identity omitted aspects of their work that they deeply valued, most notably the work reflecting the art of nursing. The art of nursing care was described in the data as work that included offering comfort, empathy and compassion, all actions that fostered human connection and a culture of care. Nurses claimed that the art of practice was jeopardized by rapid and continuous changes in health care. In particular, participants' spoke of changes, such as technological changes, that transformed nursing practice into more task-driven, outcome-focused work. Aside from challenges brought on by the implementation of new processes (e.g. Lean; standardized work) and a growing orientation toward service provision, nurses associated an increasing lack of authenticity in their practice with the use and reliance on new technologies. Participants understood technology as

both a physical and metaphorical obstacle creating distance between nurses and patients, thus compromising patient care delivery and, in some instances, patient safety.

In order to create more time to engage in the artful work of nursing, nurses, at times, played games of truth by altering their discourse to fit into managerialist discourses. For example, instead of telling management the technology was too cumbersome and resulted in less time for nurses to engage with the art of their practice, several nurses learned the value of reframing their concerns, and instead told leadership that the technology compromised patient safety. Patient safety was an important priority for both nurses and leadership, but nurses knew that using patient safety discourse would earn them epistemic legitimacy. At any given time, nurses are embedded in the interplay between multiple truths and power relations in their place of work, and are thus actors in games of truth.

When speaking of newly implemented technologies, participants felt unable to fully use their ways of knowing in nursing to provide intentional and authentic care, which challenged them morally. Moral challenges identified in the data can be further understood by relating them to one of Locsin's (2001) notion of caring, which he identified as knowing. According to Locsin (2001), knowing refers to nurses knowing that persons are participants in their care, and not mere objects of care. Nurses in this study identified that technology in their workplace contributed to the objectification of patients and hindered their authentic knowledge of patients. This challenging aspect of working with technology in practice as raised by participants is supported by Locsin and Purnell (2009), who iterate, "the coercive perpetuation of technology forces nurses to objectify persons in order to care, and challenges understandings of persons who are participating within the shared experience of a nursing situation" (p. 418). In the context of this study, nurses often associated these challenges with the electronic documentation system, where nurses felt unable to produce or receive a complete and holistic patient story. The challenges of constructing a comprehensive patient story within electronic documentation systems has been researched by Varpio and colleagues (2015), who note that electronic health

records can negatively impact clinical reasoning due to “a loss of shared interpersonal understanding of the patient story and the increased time required to build the patient's story” (p. 1019). These findings are supported by this study’s participants, who reported requiring much more time to know their patients because they were required to access multiple documents from a hybrid system (online interfaces and paper charting), which was described by one participant as a “shattered system” (participant 5, line 102).

Data suggests that when nurses experienced challenges with technology and reported these to managers, they did not highlight the epistemological issues noted above but instead focused their concerns on patient safety issues. In other words, they actually engaged in ‘games of truth’ in limited ways because they did not make full use of their knowledge to disrupt taken-for-granted assumptions about the nature of the relationship between technology and nursing. This kept their knowledge in a disqualified state, which did not foster authentic nursing practice and may have contributed to ongoing moral challenges.

Nurses engaged in multiple, emotionally demanding attempts to reconcile morally distressing events that resulted from perceived clashing ideologies of care and service. Participants felt they were only given resources to provide service, attending narrowly to biomedical needs to the detriment of holistic care. The felt inability to adequately care for patients resulted in inauthentic nursing care that challenged nurses’ abilities to also care for the self. Caring for the self is different from self-care activities (Perron, 2013). Care of the self is understood as a technology of the self (Foucault, 1988). Technologies of the self include many practices in which Foucault (1988) asserts foster authentic knowing of the self. Broadly understood, technologies of the self:

Permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, p. 18).

### Care of the Self

Care of the self is a Foucauldian concept that ascribes the ways in which individuals ought to gain mastery over themselves (Foucault, 1988). Caring for the self is achieved by knowing the self. Knowing the self is achieved by introspection, to examine the (in)consistencies between one's own thoughts and actions, and what rationales inform their conduct. Care of the self (*epimeleia heautou*) are practices and/or actions that embody "an attitude toward the self, other and the world...actions by which one takes responsibility for oneself and which one takes, changes, purifies, transforms and transfigures oneself" (Foucault, 2001/2005, p. 10-11). According to Foucault (1988), only when an individual knows them self, may they care for the self, and then in doing so, be considered an ethical subject.

There are three characteristics associated with care of the self (Foucault, 2001/2005). The first is "a certain way of considering things, of behaving in the world...and having relations with others...an attitude towards the self, others, and the world" (p. 10). Nurses divulged at length their considerations about and perceived meaning of their relationships within their workplace – to themselves, to nurse colleagues, to leadership and to patients and families. Nurses recognized that all of these relationships appeared to be eroding, and recognized the negative impacts this had on their relationship to their self. Participants recounted no longer having the time to build relationships at work. The inability to nurture these important relationships was "soul destroying" (participant 9, line 1568). The second characteristic of care of the self is being concerned with oneself, turning inward in order to attend to "what we think and what takes place in our thought" (Foucault, 2001/2005, p. 11). Participants exemplified this element of care of the self when they discussed morally distressing moments, recognizing that their thoughts, values and ideals were not always congruent with that of the larger organization. I would suggest that the interview setting itself provided an opportunity for nurses to engage with this aspect of care of the self. Nurses' abilities to reflect on their position within the world and the ways in which they were governed in their practice, as well as their capacity to

recognize incongruences between their thoughts and actions all reflect what Perron et al. (2014) described as elements of caring for the self. Care of the self is a moral practice that facilitates the development of a more authentic and ethical personal disposition.

The last requirement of care of the self is to act upon oneself (Foucault, 2001/2005), “performing acts that expose one’s commitment to oneself, to truth, and to freedom through practices of transformation” (Perron et al., 2014, p. 42). Acts that were consistent with this dimension of care for the self included engaging in nursing practices that were more authentic than participants’ current nursing practice. These included spending more time at the bedside with patients, and being more present in those moments, for example, worrying less about charting and focusing instead on the present interaction. This third aspect of care of the self included having the courage and skills to engage in political aspects of nursing work, for instance, by trying to influence decisions being made within the institution or challenging current work arrangements. The data suggests that participants struggled with this aspect of their practice, either because they feared repercussions (e.g. loss of employment) or because they felt previous attempts had failed. In light of Foucault’s (1988) work, it is clear that care of the self is a highly political process; through the development and enactment of one’s moral agency, one can identify, problematize and challenge power relations that are embedded in everyday life. Performing political acts to care for the self appeared to be difficult for nurses. Actions required to expose their commitment to themselves, their values and ideas, were dampened out of fear of persecution, as actions of this manner were often perceived as disobedient both by nurses and leadership.

When we analyze why current aspects of nursing work and the delivery of health care weighed so heavily on participants, we find significant meaning in the word *care*. Participants in this study appeared to work within an ethics of care grounded in a relational ontology, which recognizes the importance of caring and thus the significance of nurses’ actualized inability to care. An ethics of care deems that “to care for one another and to live in a web of significant

relationships are for humans an essential part of their flourishing...our relationships to others constitute our common humanity as well as our conception of selves” (Nortvedt et al., 2011, p. 194). When nurses were unable to care as they deemed essential in their practice, they not only altered relationships with patients and families, but those experiences altered their conception of themselves. This is a significant finding if we return to the self-self relationship discussed by Foucault in caring for the self. Care of the self is a technology of the self (Perron, 2013); it is an ongoing relationship that is built with oneself through unique knowledge of the self (Foucault, 2001/2005). Care of the self is exemplified through “a set of embodied attitudes and practices” (Perron, Rudge & Gagnon, 2014, p. 42).

Even though participants engaged in some behaviors that were consistent with care of the self, their discourse revealed their notion of care of the self was narrowly understood as self-care activities (work life balance, taking breaks, leaving on time). Participants nuanced the importance of what I deemed care of the self activities (not self-care activities) by limiting the discussion to the impact of caring for the self on patients, excluding any consideration of the impact it had on themselves. Data suggests that nurses deemed care of the self important insofar as it translated into a concern for patient well-being. For example, participants explained that when nurses engaged in certain acts to uphold their values, they were doing so out of concern for patients. In other words, the patient was a condition for which nurses could engage in what we might call care of the self practices. It appears even the participants could not extricate themselves from the power relations that tie them to patients. Participants did not realize how they might limit themselves and their capabilities by tying their own interests to those of patients. In doing so they restrict their ability to care for the self, independent of the needs of patients. This finding is consistent with the work of Perron et al. (2014), who suggest “nurses are socialized to see themselves as extensions – of their professional organizations, their workplace and even their patients” (p. 46). Participants discussed their experiences of

moral distress, for example, as manifesting through the inability to adequately care for patients, not the inability to adequately care for the self.

The inability to care for the self and other is as significant as the ability to care, to the extent that “ethics of care addresses the harm that can occur as a result of lack of care, both on a daily and on a long-term basis, in the relational webs of which we are part” (Nortvedt et al., 2011, p. 194). In the data from this study the inability to care was at the very core of nurses’ moral distress. Participants recognized that the inability to care according to their values and education posed potential and actual risks of harm to patients. Participants acknowledged micro-ethical moments in their day-to-day work where they were challenged to care, and these triggered enduring feelings of guilt and inadequacy. This finding is supported by Mercy and Flynn (2017) who suggest, “it is through micro-level interactional episodes that identity is transacted and that individual worth is developed or damaged” (p. 40). Participants internalized systemic issues related to the allocation of resources despite understanding that those decisions were made by higher-ranking administrators. Participants also highlighted how morally distressing the bigger picture was for them; shifting ideologies of health care delivery on a larger, more global scale weighed heavily on nurses’ moral conscience. Participants recognized that the organizational constraints that made caring so difficult were not unique to their specific units or workplace, extrapolating their experiences to reflect those of nurses across the country. Such macro level thinking is congruent with an ethics of care whereby care can be understood as both a moral and a political concept:

Human beings are part of relational networks where reciprocal care and trust, attention and response are vital in the public domain and in the politics of governments, and lack of care is as harming in public as it is in private relationships (Nortvedt et al., 2011, p. 194).

Nursing is, by its very nature; political, and caring is thus a political act (Perron, Fluet & Holmes, 2005). When we articulate care, and care of the self, as political concepts, we invite the

deconstruction of taken-for-granted assumptions about the concept of care and the contexts in which care does or does not occur. At a macro level, organizational discourse reflects how HCOs understand, shape and govern care. Indeed, from an ethics of care perspective, “health care organizations must create space and time for care to flourish...for an ethics of care in a medical setting, the relationship to patients has a value greater than caring instrumentally for their medical needs” (Nortvedt et al., 2011, p. 198). Participants in this study clearly articulated that current change initiatives in their workplace governed their nursing work in ways that prioritized instrumental service delivery, which they deemed unethical and immoral. Participants consistently reported feeling pressured to provide what they perceived as sub-optimal care in order to meet financial targets, creating moral distress in their day-to-day practice.

A mounting body of literature has highlighted “that moral distress is a significant concern in nursing that can lead to profoundly disturbing personal experiences” (Carnevale, 2013, p. 35). The experience of moral distress strongly influences nurses’ decisions to leave practice environments and at times, the profession altogether (Corley, 1995; Corley et al., 2001; Hamric, 2000; Millette, 1994; Wilkinson, 1998). Moral distress “is a function of many factors” (Hamric, 2000, p. 200). What remains under-examined in current scholarship is how rapid and continuous organizational change may contribute to moral distress. Often health care ethics and moral distress discourses are framed exclusively in relation to patient-health care provider relations, overlooking the organization-health care provider relations. Participants evoked multiple events in their practice outside of the direct patient-health care provider relationship that they “constitute as ethically meaningful” (McMurray, Pullen & Rhodes, 2010, p. 543) insofar as they “formulate a motivated moral response to them” (p. 543). The ways nurses spoke of their relational positioning was complex; their relationships with the organization, colleagues, patients and families framed nurses as ethical subjects.

Ethical subjectivity is the ways in which individuals work to define their ethical position as it relates to their day-to-day practices (McMurray et al., 2010). Foucault (1984a) understood

ethical subjectivity relates to how individuals constitute themselves and their adoption of practices in the formation of an ethical self. When nurses were unable to practice in ways that truly enacted their ethical positions (and thus ethical self) they experienced moral distress. The data from this study suggests that the root cause of moral distress for these nurses has been the multiple negative impacts of rapid and continuous organizational change in their workplace that compromised their abilities to adequately care for patients. Participants reported having little control over changes processes yet they felt morally obligated to reconcile the negative impacts of change initiatives on patient care delivery.

When organizational decision-making created moral conflict for nurses, they were compelled to rectify these conflicts. Participants recognized that if they worked exactly how the institution expected them to (perceived to be driven by efficiency and cost saving) both patient integrity and nursing integrity would be challenged. Their recognition of these challenges and potential negative outcomes on patient care delivery are consistent with Nortvedt et al. (2011), who assert, "If priority decisions too frequently conflict with factors that produce well-being and health at the individual level of care, the result could be nurses increasingly violating their commitment and responsibilities to individual patients" (p. 198). Data shows how some participants' exercise of power remedied the potential violation of their commitment and responsibilities, for example through resistant and transgressive actions. Some participants utilized resistance and transgression to facilitate nursing work that was more morally authentic to the self. Some opened resistant spaces where dominant discourses could be challenged and where nurses tried to reconstruct/enact nursing practice on their own terms. Engaging in acts that deviated from established practices and institutional expectations were described by participants as enabling them to better care for patients, most often by creating more time at the bedside to provide nursing care. Caring, moral agency and power have previously been linked in nursing scholarship (Traynor, 2012). In Traynor's (2012) research findings nurses' construction of caring was highly moral, and nurses often acted in resistant ways to provide

what they deemed quality care. Nurses require some level of freedom to exercise discretionary autonomy over their practice to fully engage as morally authentic individuals (Traynor, 2012).

The data from this study suggests that moral authenticity is what nurses ultimately strive for in their practice. According to Packard and Ferrara (1988), moral authenticity can only be achieved through a practice grounded in a relational ontology: “Nursing work thrives where empathy and sympathy are permitted to enter...Nurses ‘do’ nursing when their practice centers on persons, and they ‘do’ something else when they act on mere bodies, machines and report forms” (p. 69). The foundational attributes of nursing, most notably human connection, require time, something that participants consistently described as insufficient under current working conditions. Participants described what Nortvedt and colleagues (2011) call “relational responsibilities” (p. 192), a felt moral obligation and desire to create meaningful human connections in practice. These responsibilities reflect nurses’ unique conceptualizations of the characteristics of care. Such moral obligations and desires are grounded in morally authentic nursing practice. When nurses in this study were not allotted the time required to ground their practice in relational and morally authentic ways, most notably through the enactment of emotional work, nurses described morally distressing moments where human connection was compromised.

Many participants described nursing as more than “just a job”, but what that meant was difficult to articulate. Understanding the moral foundations of nursing help ground the complexities of nursing work amidst rapid and continuous change. Packard and Ferrara (1988) clarify these complexities in their discussion on the moral foundations of nursing:

Nurses are not able to do the right things for patients and themselves in their jobs...indicating a distinction between nursing as work – a life’s work – and nurses’ jobs. The work of nursing is more than the nurse’s (hospital) job. There is widespread recognition among practicing nurses that their jobs interfere with and misdirect their work (p. 68).

Packard and Ferrara's quote help envision how participants view nursing as a life project that reflects living morally and acting in morally authentic ways. To do this, nurses made initial commitments to themselves that they now had to compromise because of organizational restrictions and increased governance of nursing work. When nursing is understood as a life's work that is comprised of both the care of others and the care of the self, we see "how a nurse's commitment to the self is altogether compatible with the nurse's commitment to others, whether they be patients, in the usual sense, or people in the broader sense" (Packard & Ferrara, 1988, p. 69).

Participants described certain practices that could be interpreted as care for the self as an important aspect of nursing work, in so far as nurses described the importance of authentic practice, and the consequences of inauthentic practice. The analyzed narratives exemplified multiple examples of nurses' sacrificing care of the self. This was evidenced by the inability at times, to provide care in authentic ways. Most notably, nurses recognized they prioritized other discourses and associated actions, for example managerial discourses and technocratic ideas of nursing work that fulfilled managerial ideals. Although participants recognized this issue and offered critical reflection and insight, they often felt unable to rectify these challenges in their work environments. The complex nature of caring for the self is best understood if framed as "inevitably social and embedded in our relationships with others who assist and facilitate our self-examination and care" (Catlaw et al., 2014, p. 198). The desire to care for the self, to exercise self-concern over one's own well-being, was perceived by some nurses and leadership to be what Foucault called "a sort of moral dandyism" (2001/2005, p. 12). This is a perceived egocentric and selfish disposition of self, something historically constructed as unprofessional and against the interests of patients (Perron, 2013; Perron et al., 2014). Care of the self was not constructed as a valid component of nursing work. The idea of moral dandyism shaped dominant nursing and health care discourses in the data, and thus the truth claims that informed what nursing work consisted of.

Care of the self was difficult for nurses because, as Catlaw and colleagues note (2014), dominant truth and knowledge claim within organizations “separates truth and the subject; truth is now located in a domain apart from one’s lived experiences” (p. 201). In the nursing context, dominant knowledge and truth claims perpetuate narratives of selflessness and altruism at the cost of the self. This is internalized and perpetuated by nurses, including participants in this study. Self-care is relational work that reflects the forging of a continuously evolving relationship with the self, “It is the cultivation of such self-care that permits us to differentiate the boundaries between ourselves and the roles we occupy in organizational life” (Catlaw et al., 2014, p. 214). Relational work with the self allows individuals to learn how to govern themselves and act in ways authentic to one’s personal truths. Care of the self, as articulated by Catlaw et al. (2014) “seeks to actualize *truth in existence* – rather than truth as knowledge” (p. 207). Care of the self is one way in which individuals attend to themselves and the world around them. Participants described their work worlds and their practice as embedded within multiple moral obligations and ethical encounters, noting that the current realities of their workplace challenged their abilities to act in ways that were authentic to their personal truths about their moral obligations in their nursing practice. It is notable that nurses’ personal truths are created from discourses that have historically been cultivated by and imposed on nurses for decades, including notions of devotion and self-sacrifice (Anthony & Barkell, 2008; Bear, 2009; Heskin, 1997; Nestel, 1998; Schultheiss, 2010; Stanley, 2008). Buresh and Gordon (2013) suggest that such notions have historically silenced nurses and thus made oppressive work environments the status quo. Nurses may be trying to liberate themselves from oppressive organizational processes using discourses grounded in care, as these are the discourses that both resonate with and define nurses in their practice. This can be disempowering and oppressive when nurses make assumptions that others outside of nursing (leadership, management) inheritably understand care and associated caring work in the same ways nurses do.

## Parrhesia

Actualizing truth in practice proved challenging in the current climate of rapid and continuous change, most notably because participants felt silenced or dismissed within their workplace when attempts were made to articulate their knowledge and truth claims regarding nursing work and care delivery. Fear of reprisal often stopped participants from speaking their truths. Truth-telling is an important aspect of nurses' relation to the self (Perron, 2013). Foucault (1988) understood truth-telling as another technology of the self, in addition to care of the self. Foucault examined this concept of truth-telling in his later years, which he termed parrhesia.

Parrhesia is understood as the capacity and will to “say something dangerous – different from what the majority believes” (Foucault, 2001, p. 15). According to Foucault, “parrhesia occurs when a speaker speaks an unwelcome truth or gives unwelcome advice to a powerful person or group” (2001, p. 9). Foucault described five conditions of parrhesia: frankness, truth, danger, criticism and duty (Foucault, 2001; Perron et al., 2014). Frankness refers to the sharing of one's true thoughts, without masking it. Frankness involves the rejection of rhetoric (Perron, et al., 2014), choosing instead a relationship to the self as “truth-teller rather than as a living being who is false to [her/him] self” (Foucault, 2001, p. 17). The second condition, truth-telling, refers to what is neither the “result of a reasoning process nor the product of scientific inquiry” (Perron et al., 2014, p. 41), but rather what is “acquired through certain qualities and dispositions” (p. 41). This means “there is always an exact coincidence between belief and truth” (Foucault, 2001, p. 14).

The practice of parrhesia requires that individuals convey their truth to others, which always entails elements of risk. When one speaks their truth, it may be dangerous as it may challenge dominant discourses. Danger is the third condition of parrhesia, where “parrhesia then, is linked to courage in the face of danger: it demands the courage to speak the truth in spite of some danger” (Foucault, 2001 p. 16). Danger comes from speaking truth to a person

who is in a position of authority over the speaker and can damage their relationship. An individual who chooses to practice parrhesia risks undermining relationships with peers and those in power, specifically risking breaking or ending those relationships. Rigid hierarchies and authority, which often characterize nurses' work environments and contribute to their oppression (Bishop, 2004; Daiski, 2004; Hutchinson et al., 2006; Jackson, Clare & Mannix, 2002; Roberts, 1983; Roberts, Demarco & Griffin, 2009), can lead nurses to feel at risk of being targeted and losing employment if they speak against widely accepted discourses.

The second last condition of parrhesia is criticism. Criticism is aimed at the interlocutor, "for in parrhesia the danger always comes from the fact that the said truth is capable of hurting or angering the interlocutor" (Foucault, 2001, p. 17). Criticism occurs when the parrhesiast tells the interlocutor how they ought to act in certain ways, or that they are wrong in how they act, speak or think (Foucault, 2001). Parrhesia is a critique of some action, speech or thought. The fear of criticizing those in positions of superiority (leadership) was noted in participants' narratives when they recounted why, at times, they forewent speaking up in their workplace, fearing it may "put a target" (participant 7, line 253) on their back. Nevertheless, participants recognized they had a duty to speak up about aspects of their work that negatively impacted patients, which represents Foucault's (1997) fifth and final condition of parrhesia, duty. Duty is the feeling that speaking up "is the only possible ethical conduct" (Perron et al., 2014, p. 41). Parrhesia is the practice of free speech as a matter of duty. Perron et al. (2014) suggest that not speaking, and keeping silent leaves a parrhesiast feeling untrue to her or himself. This appeared to be true for participants in this study, who felt a duty to speak but often did not, or could not find appropriate avenues. Silence may have contributed to their experiences of moral distress.

Foucault "chose to explore the ontological implications of parrhesia for human subjectivity" (Walzer, 2013, p. 2) speculating "who is able to tell the truth, about what, with what consequences and with what relations of power" (Foucault, 2001, p. 15). Parrhesia can be

related back to the concept of voice, a central concept to this study. Participants constructed voice as a means to speak out, describing the need for frankness and the expression of their truths and the duty to do so for patients' wellbeing. Participants also described the danger and criticism that accompanied raising one's voice when it went against dominant managerial discourses within their place of work. This connection provides insight into how voice may be constructed, as a full-fledged element of care. To voice truth, even when it goes against dominant discourse, is to care.

Foucault's ideas about parrhesia provide profound insight into nurses' experiences of rapid and continuous organizational change. Critical management scholars note that organizations are saturated with power relations that work in complex ways (Alvesson & Deetz, 2000; Knights, 2009). These include influencing nurses' capacity to practice parrhesia within the context of their organizational lives. The capacity to speak truth is shaped by relations with others and one's self, as Foucault (2008/2011) stated:

In posing the question of the government of self and others, I would like to try and see how truth-telling (*dire-vrai*), the obligation and possibility of telling the truth in procedures of government, can show how the individual is constituted as subject in the relationship to self and the relationship to others (p. 42).

One of the noteworthy characteristics of parrhesia is the associated risk that an individual will not be heard, or that others will not value their truths. Foucault (2008/2011) recognized that truth-speaking carries relational risk:

It involves some form of courage, the minimal form of which consists in the parrhesiast taking the risk of breaking the relationship and ending the relationship to the other person, which was precisely what made his discourse, possible. In a way, the parrhesiast always risks undermining the relationship, which is the condition of the possibility of his discourse (p. 11).

In the context of organizational change, risk is often considered within the context of the organization as a whole, such as loss of profit (Buchanan & Fitzgerald, 2007; Kotter, 1995) or damage to its reputation. Rarely is risk associated with individual gain or loss. This concept of risk demonstrates the tendency of dominant organizational discourses to explore and explain systems with less attention to the people within them. To accept associated risks and practice parrhesia, the bond between a speaker's words and thoughts must over-ride the bond between speaker and listener (Foucault, 2011). This differentiation can be extremely difficult for nurses within complex, political and power-laden organizations. Practices associated with the normalization of rapid and continuous organizational change (for example, the disqualifying of certain aspects of nurses' knowledge) creates tension between nurses' thoughts and speech, leading to self-doubt and feelings of guilt. It can also generate a climate of fear with regards to the potential consequences of speaking up.

Such fear is pervasive in workplaces subject to significant change. For example, Armstrong and Armstrong (2003) noted this fear within contemporary Canadian HCOs in their research: "It is hard to work effectively for the company when you live in fear. Cutbacks and new managerial approaches have left a legacy of fear" (p. 120). In addition, in the eyes of the interlocutor, parrhesiastic speech can easily be interpreted as an act of disrespect or disobedience, rather than an act of courage. Though parrhesia describes a process through which true speech can be realized, the act of listening holds the same importance as the act of speaking. Listening is a central concept within the relationality of parrhesia:

The people, the Prince, and the individual must recognize that they have to listen to the person who takes the risk of telling them the truth...this kind of pact, between person who agrees to listen to it, is at the heart of what could be called the parrhesiastic game...parrhesia is the courage of truth in the person who speaks and who, regardless of everything, takes the risk of telling the whole truth that he thinks,

but it is also the interlocutor's courage in agreeing to accept the hurtful truth that he hears (Foucault, 2008/2011, p. 12-13).

Listening, on the part of nurse managers, emerges as a choice in the data. While participants described many instances of not being listened to, there were also illustrations of nurse managers paying attention to nurses' concerns. Those participants who felt their concerns were heard at times, described having managers who took a democratic approach to leadership. Alternatively, nurses' abilities to be heard when working under authoritarian management appeared to be conditional on nurses' ability to convey their message in a way that nurse managers recognized. A few participants recalled doing just that, ensuring their requests for staffing and resources strategically focused on patient safety concerns as opposed to nurse workload concerns. Doing so reflects nurses' understandings of organizational power relations. Appropriating the language disrupts these power relations, which can force nurse managers to consider nurses as legitimate contenders in decision-making. Such acts on behalf of participants may be the result of nurses having little space to safely speak authentically. Speaking in ways that may be inauthentic diminish the risk of speaking up because nurses' speech is more aligned with managerial discourse. Speaking in such ways runs the risk of perpetuating the misbalancing of organizational priorities (e.g., patient safety) over nursing needs (e.g., manageable workloads). Organizations must create a culture where it is safe to speak authentically, where the threat of the use of power is replaced by a collective will to enact moral practice. According to Boyle and colleagues (2001):

The health care organization cannot expect its associates to be moral heroes on a regular basis. The reality of power relationships, and many staff members' perceptions of power and its possible use against them, mitigates against the likelihood that most employees will take courageous positions or even raise uncomfortable questions (p.55).

Participants did not recognize truth-telling as an act of courage, it was perceived solely as an act associated with risk. Not recognizing parrhesia as an act of courage that could bring nurses closer to morally authentic practice may perpetuate an already existing culture of silence within nursing (Buresh & Gordon 2013). Some participants described the inability to speak their truths, or suggested that their truths were filtered and interpreted in different ways by leadership, such as being bitchy or just complaining. When this occurs nursing knowledge and experience is less likely to be accurately incorporated into dominant organizational discourses. Phenomena such as organizational change will remain grounded in perspectives that do not reflect the realities and complexities of nurses' work. From a relational perspective, it becomes important to examine the organization as a whole in terms of its obligations to support nurses in their enactment of morally authentic nursing practice. According to Carnevale (2013), organizations are responsible for developing "Clear and safe channels...for nurses to voice their moral concerns as high in the organizational hierarchy as possible." (p. 37).

Historically, moral distress has been regarded as an individual issue as well as an inevitable part of nursing. It results from the individual nurse's weaknesses, remedied by rest (time away from work), adjusting coping strategies or altogether leaving the organization (Carnevale, 2013). Participants in this study similarly described their internalization of this personal weakness narrative in ways that made them question their competency and their fit within their rapidly changing workplace. Many participants wondered whether their perceived shortcomings were to blame for their distress. Carnevale (2013) suggests that "Individual nurses are not free to shape the ethical standards of their profession, nor are they free to act in any manner that they individually choose. These standards and actions are always socio-politically embedded." (p. 36). Understanding the moral basis of nursing requires an examination of the complex relational socio-political contexts within nurses practice. Often nurses are confronted with practice environments that obstruct their abilities to uphold their own moral standards. The experience of moral distress "can be an indicator of weaknesses in the practice environment

rather than nurses' weaknesses" (Carnevale, 2013, p.35), suggesting organizations too have moral obligations to uphold and failing to do so constitutes a problem of the practice environment, not the nurse. One way to examine the moral obligations of an institution is through the concept of institutional integrity.

### **Institutional Integrity**

According to Preston and Samford (2002), the first theorists to describe institutional integrity, the enactment of the concept is understood as follows:

Institutional integrity involves an institution asking hard questions about its value and values, giving honest and public answers, and living by them. Doing so for an institution is more complex than for an individual but it is both possible and necessary.... An organization has integrity if it lives by its answers. However, it does so in a different way to an individual. It cannot merely be a personal commitment but must be an institutional commitment (p. 41).

Participants in this study described a lack of resources or supports to enact the values and mission the institution had publicly declared. According to participants there was little institutional commitment to staff to uphold the values and mission of the organization, suggesting that the organization may have work to do in fostering institutional integrity.

In her 2003 text entitled, *Institutional Integrity in Health Care*, Smith Iltis asserted that HCOs have, over time, become powerful institutions that now decide who, how and when society receives care. Therefore, HCOs are in the midst of "the social world of relationships, health care organizations can now be seen as bearers of moral obligations subject to acting in ways that are good and bad, right and wrong" (Smith Iltis, 2003, p. 1). I have chosen to focus this section of the discussion on the concept of institutional integrity because, as articulated by Smith Iltis (2003), it is a key concept that can be used to evaluate how HCOs do or do not live up to their moral obligations. There is much debate in current scholarship as to *how* and *who* should judge institutional integrity, and thus organizations' fulfillment of their moral obligations

(Smith Iltis, 2003).

*How* morality ought to be judged can be through the determination of whether or not organizations live up to what they have proclaimed as their values (Arnett & Fritz, 2003). Arnett and Fritz (2003) state that organizations of integrity maintain “a story or narrative that identifies [their] core values (mission)...supported by...social practices that give life to those values” (p. 41). In HCOs, this is often constructed through publicly available mission and vision statements and publically articulated commitments to care (Ells & MacDonald, 2002). Employees ought to bear witness to the same declarations committed to the public, and the organization should be equally accountable to employees. The collective narrative created by participants in this study described an organization that did not fully uphold its moral obligations to patients and nurses, and that failed to enact fundamental principles of institutional integrity. Participants asserted that leadership made decisions in support of “excellent”, “quality” and “safe” care; yet, participants also divulged that many actions undertaken to reach those goals fell short. In addition, when leadership became aware of some of the effects of their decisions (e.g., errors in care, increased number of nurses on prolonged sick time, increased staff turnover), nurses suggested little was done to rectify these concerns. Mantel (2015) notes that:

Consequently, the integrity of patient care delivery depends on the integrity of the organization’s culture, that is, whether the decisions and behavior at all levels of the organization align with the health care organizations values and fairly balances business and patient welfare concerns (p. 662).

The data suggests there was an unequal balancing of business orientation and patient welfare during multiple change initiatives, exemplified by the privileging of service over care, a significant contributor to participants’ moral distress.

Incongruences between the HCOs’ claims and actions amidst multiple and ongoing change initiatives have negative impacts on nurses. Participants felt cynicism and loss of trust when they described ways in which their organization failed to create mechanisms that provided

nurses with what they needed to enact the values of the organization, most notably “family centered care” (participant 2, line 539; participant 5, line 367; participant 10, line 81) and “holistic care” (participant 2, line 117; participant, 5, line 388; participant 10, line 106). Smith Iltis (2003) and Telford (2004) observed similar occurrences of cynicism as a result of incongruences in organizational speech and action, which generated mistrust amongst nurses. As discussed previously, the inability to provide holistic and family centered care created morally distressing situations for nurses. Boyle and colleagues (2001) attribute these kinds of morally distressing situations amongst health care professionals to inconsistencies in an organization’s moral culture, which reflect a “failure to achieve ethical alignment” (p. 54). Even if certain values were implicit in an organization’s mission statement:

The lived moral experience of those working in the organizational may contradict...even if those values are implicit in the in the organization’s mission statement...people may cite instances in which their desire or actual efforts to do the right thing have been frustrated by some feature of the organizations policy, prevailing practice, or moral climate (Boyle et al., p. 54).

Organizations may work in ways that disable employees from enacting the organization’s stated missions and values. Organizational values ought to drive organizational decisions and actions, but at times do not (Ells & MacDonald, 2002; Mantel, 2015), and are instead, as Hall (2004a) described, “too easily displayed as window dressings that are honored only through lip service” (p. 421). This lip service was noted by participants who described “smokescreens” (participant 8, line 364, 826) and not wanting to “play the puppet” (participant 5, line 251) to support the organizations “hypocrisy” (participant 5, line 41). Change initiatives that align with the ideologies and values of managerialism were repeatedly described by study participants in ways that strongly contradict nurses’ beliefs about care delivery and their interpretations of the core values of the hospital. What is truly needed is a commitment of moral obligations embedded into all aspects and levels of organizations, in the “structures and processes that

support the organization's articulation of its core values, internalization of those values among its members, and integration of the values into both daily operations and long-term planning" (Mantel, 2015, p. 663). Recognizing contradictions between health care ideologies and practices makes an examination of ethical practices within HCOs necessary, especially in organizational research (Clegg, Kornberger & Rhodes, 2007).

Multiple participants noted contradictions between health care ideologies and practices. Participant 3 described examples of these inconsistencies through the use of what she called "propaganda" (participant 3, line 488), a form of corporate branding used by leadership. Participants 3, 6, 7, 9 and 11 noted corporate branding through both public and internal media campaigns. Corporate branding was used in different ways to project a commitment to a culture of care to patients, families and the public. Participants described this commitment as incongruent with the nurses' realities of feeling the HCO was driven by a culture of service. This rupture between public image and employee reality is important in assessing organizational integrity because the image portrayed to the public was pillared upon values, beliefs and commitments that, according to participants, the organization failed to enact. Moral inconsistencies reflect failure to achieve ethical alignment, creating work environments where, at the organizational level, staff witnesses an inability to apply its own values in a consistent manner. According to Boyle and colleagues (2001), "staff then feel unsupported in pursuing the good they believe they should pursue; some may even report the organization discourages them from doing the right thing" (p. 55). Participant reflected feeling unsupported and at times, discouraged, from doing what they perceived to be the right thing. Following the implementation of a significant change initiative in her department participant 9 remembered being told, "you have to be faster, is there any way you can cut corners?" (line 337).

Repeated inconsistencies in an organizations' moral climate create "deepening moral cynicism and dampening of morale" (Boyle et al., 2001, p. 55). In addition to cynicism, participants described decreasing morale as a result of multiple change initiatives that took

nurses further away from morally authentic nursing work. In order to regain the trust of staff and minimize cynicism, leadership of a HCO must provide staff with authentic and truthful explanations of decision-making, practices and policies (Cameron & Green, 2015; Gokenback, 2016; Kelly, 2012; Page, 2004). Participants discussed at length the need to be given honest explanations vis-à-vis decision-making because trust is only garnered when administrators do what they say they will. “Congruence of word and deed determines the difference between a culture of cynicism, resulting in the destruction of institutional integrity and ethos, or one of trust, resulting in the maintenance of institutional integrity and ethos” (Arnett & Fritz, 2003, p. 67).

The leadership of an institution should embody integrity. Participants provided multiple examples of being told to change aspects of their practice related to the implementation of change because leadership said so, as opposed to being provided evidence-based rationale. Nurses found this problematic. According to Boyle (2001), “truth-telling is a prerequisite for organizational operation... it is difficult to live and flourish in a community where everyone is unsure about who is telling the truth” (p. 14). Participants’ difficulty in discerning who was telling the truth about change initiatives raised ethical concerns for me, as a researcher.

Institutional integrity is, as noted by Preston and Samford (2002), intrinsically woven into ethics, which differs from morality, and thus morals. Distinguishing the two is important now as this discussion moves into an ethical ethos. *Morality* is “the lived experience of making choices, and *ethics* is systematic reflections on that lived experience” (Boyle et al., 2001, p. 13). Morality was seen in nurses’ narratives when they recounted micro-moments in their practice where they had to make difficult choices that, when analyzed, often resulted in moral distress. Ethics was notably visible in nurses’ reflections of how their experiences of living with rapid and ongoing changes mediated relationships to themselves, others, society, history and culture. Participants prominently described ethics in relation to their work organization, describing ways in which institutional practices resulting from change initiatives were “unethical” (participant 9, line 423). Participants’ discussions of morality (their experiences of decision-making) and ethics (their

reflection on those experiences) were deeply rooted in the complexities of the HCO. Their ethical reflections require further examination of ethics from an organizational lens.

### **Ethical Health Care Organizations**

Ethical HCOs are acutely aware of, sensitive and responsive to the “moral lives of individuals within care institutions” (Boyle et al., 2001, p. 4). Current scholarship, however, often fails to address the moral life of institutions as institutions, rather research in HCOs has focused on ethics in the contexts of individual care provider-patient relationships (Boyle et al., 2001). Focusing solely on individual moral lives hinders the recognition and identification of ethical problems that exist beyond interpersonal relations. In examining the moral life of an institution, moving beyond the moral lives of individuals, it becomes apparent that predominant organizational ethics discourse is missing a discussion about the ethical and moral obligation that organizations ought to have towards individuals, both within and beyond the institution. In order to fulfill their ethical and moral obligations, HCOs must fulfill obligations to the multiple groups of individuals, including frontline nurses, who are responsible for health care delivery. Organizational scholarship must pay attention to the extent to which organizational cultures do (or not) promote a care environment that facilitates nurses’ enactment of their moral obligations, in this case, family centered and holistic care.

It is fruitful to expand the understanding of ethics in HCOs to include an examination and articulation of the role that managerialism plays in the enabling or disabling of organizational ethics and integrity (Bell & Breslin, 2008; Ells & MacDonald, 2002; Hamric, 2000). This discourse must move forward, because, as Mantel (2015) articulates: “Health care organizations’ failure to take a more global approach to organizational ethics risks an organizational dynamic that results in poor quality care, inefficient care, or the under treatment of patients” (p. 662). Participants recognized that multiple change initiatives in their place of work resulted in what they deemed poor quality care, inefficient care delivery, and at times,

under or incorrect treatment of patients. These events created morally distressing experiences for nurses in their day-to-day practice. The findings from this dissertation offer new insights into the ramifications of managerialism on morality and ethics in health care. This conversation must move into mainstream and formal discussions regarding the current state of health care in Canada.

There is a need to reflect upon and study ethics and morality in HCOs because: “Ethical reflection and moral living promote integral human fulfillment...ethical reflection and action pursue values that allow humans to flourish as individuals and communities” (Boyle et al., 2001, p. 14). The moral dilemmas participants described threatened or impeded their individual and collective ability to thrive. HCOs and the leaders within them are ethically and morally bound to create and support environments where nursing staff have the training, time, support and resources to provide safe, competent, moral and ethical care. Results of this study describe a strikingly conflicting work environment. Critical management scholars have argued that critical interrogation is required to explore the multiple ways in which organizations work to support certain discourses (e. g., managerialism) and individuals (e. g., administrators) while dismissing others (see for example, Alvesson & Deetz, 2000; Beil- Hildebrand, 2005; Kitchener & Leca, 2009; Knights, 2009; Learmoth, 2003; Martin & Learmoth, 2012). HCOs could benefit from acknowledging the capacity of organizational decision-making to legitimize certain discourses over others, thus supporting or hindering institutional integrity.

Reiser (1994) suggests that as HCOs have evolved over the last century, their ability to exercise authority has amplified, yet these organizations have not given adequate attention to “the essential associations that exist among their constituents, to the values generated and used in interactions, or the role of the organization itself in fostering humanness in the relationships and environments of the workplace” (p. 28). This idea of humanness reflects what participants described as an essential component of caring and morally authentic nursing practice. Participants reported feeling as though they were losing significant human connections

in their work as a result of rapid and continuous changes. When analyzed using a critical management lens, it was apparent that changes were increasingly inspired by managerialist ideologies. Participants articulated that the need to reclaim the human dimensions of their practice was imperative to the act of caring. During ideological shifts towards managerial inspired, service driven models which are pillared upon cost saving and efficiency measures, organizations do not appear to reflect on how such a shift impacts ethical integrity. Corley and colleagues (2005) note that cost pressures (fiscal restraint) and resulting inadequacies to staffing levels are heavily affecting nurses and contributing to increasingly morally challenging workplaces. Villeneuve and MacDonald (2006) reflect what participants in this study reiterated on multiple occasions: “the [Canadian] health care system is not working well enough, either for those it serves or for those who work in it. The pace of change is relentless” (p. 22). Here we are reminded that the pace of change is beyond individual nurses’ control, but rather lies in the hands of institutions within a broader health care system. It is the relentless pace of change within institutions that directly contributed to the elements of change fatigue found in the data. Change fatigue may therefore be a symptom of poor institutional integrity.

The urgency of critically examining institutional integrity by HCOs is heightened by the moral challenges created in nurses’ day-to-day practices. Day-to-day decisions that nurses must make have been described as micro ethics (Trough et al., 2015) or everyday ethics (Hamric, 2000). When nurses are unable to be morally authentic in these micro or everyday ethical moments they experience moral distress (Hamric, 2000). In other words, nurses experience multiple situations within a day when they, based on institutional factors, are morally challenged, resulting in either the enactment of moral values or feeling as though they failed to do so.

Participants identified that their attempts to mediate and rectify morally distressing moments resulting from multiple change initiatives were often through resistive and transgressive behavior, for example through the manipulation of technology, and not attending

daily unit meetings. By attempting to minimize or rectify morally distressing situations participants made use of micro-ethical moments to enact their moral disposition. In doing so, they often felt they did not live up to the organization's expectations, but they did live up to their own. These acts of resistance and transgression were a means to obtain greater autonomy over their practice, and create "a form of relation to the self that enables an individual to fashion himself into a subject of ethical conduct" (Foucault, 1984b, p. 251). This relation to the self defines individuals by "determining how the individual is supposed to constitute himself as a moral subject of his own actions" (Foucault, 1997, p. 263).

This strategy could be counterproductive and result in unintended effects. Nurses enacting workarounds or engaging in resistive and/or transgressive behaviors to "make it work" (participant 4, line 229; participant 8, line 600; participant 10, line 573) could actually help conceal HCOs failure to uphold institutional integrity. Patients received appropriate care, not because HCOs were upholding their moral commitments, but because nurses compensated for organizational shortcomings. While nurses appeared to engage in care of the self, activities in these immediate micro-ethical moments, their actions could inadvertently be interpreted by leadership that nurses were indeed able to work within the current environment, and were successfully adapting to rapid and continuous changes. The urgency of nurses' concerns could therefore be tempered by their seeming ability to cope, thus maintaining the status quo.

These behaviors were, nonetheless, grounded in nursing knowledge and reflect attempts to engage in morally authentic practice. From Foucault (1984) we understand that ethical subjectivity requires the ability to exercise some form of freedom from subjectification. McMurray et al. (2010) suggests that "the ethical self is creative in that it styles itself in relation to, in resistance to, and in excess of those discourses that would discipline it into particular positions" (p. 544). Resistant and transgressive acts as understood in the context of this study, are significant because they enabled nurses to enact disqualified knowledge. Nurses created and used workarounds in ways that allowed them to open up morally authentic spaces in their

practice. These behaviors constituted political acts that reflected attempts to care for the self. Participants who acted in resistant or transgressive ways were political agents - a form of agency seen as disobedient by organizational leadership. Participants recognized the importance of both speaking and enacting one's knowledge and one's truth within their rapidly changing workplaces, but also recognized doing so was not without risk. The acts of truth speaking (parrhesia), resistance and transgression can all be understood as components of political agency.

### **Nurses as Political Agents**

Relational ontology frames the ways in which nurses' enacted agency in this study. Catlaw et al. (2014) clearly articulate this framing in the following way: "Agency is an artifact of a set of relationships that is subsequently enabled or disabled by the context in which it is exercised" (p. 213). Nursing is political because it is relational (Perron, 2013; Perron et al., 2014).

The focus now turns on a specific aspect of political practice: political agency. Political agency is a combination of political consciousness, as defined by nursing scholars Leavitt, Chafee and Vance (2007), and agency, as defined by critical management scholars. Political consciousness can be understood as the "aha' moment" (Leavitt et al., 2007, p. 36) in which a nurse (either throughout formal training or in practice) "becomes most focused on specific issues relating to one's practice rather than on the large issues" (Leavitt et al., 2007, p. 36). This transition is important because nurses in this study perceived themselves as powerless in macro level politics, but exercised power over their practice, and thus the health and well being of patients, in micro moments. This shift in thinking is imperative in moving the notion of politics from a macro to a micro level.

The recognition that nurses are embedded within a complex system of politics at the micro level is necessary for nurses to then enact agency in micro level politics. According to critical management scholars, individuals are influenced by discourses but yet have the agency

to decide how to let such discourses influence them and their work (Bergström & Knights, 2006; Thomas, 2009). Thomas notes, “individuals are located in social contexts that both constrain and sustain the enactment of agency” (Thomas, 2009, p. 170). Therefore, nurses must first recognize how political discourses impact their day-to-day work before then can decide how to engage with such discourses. Agency is understood as “intersubjectively constructed within asymmetrical relations of power” (Willmott, 1994, p. 92), accompanied by an “understanding that the realization of an ‘authentic’, autonomous mode of being is conditional upon a transformation of these relations in the direction of greater symmetry” (Willmott, 1994, p. 92). Critical management scholars trust that “those who are oppressed in organizations” (2016, p. 170) have the capacity to “challenge and eventually overthrow the prevailing reality” (2016, p. 170). Nursing scholars Leavitt et al. (2007) attest that “All nurses have the opportunity and ability to engaging in politics. One needs only the desire to start” (page 45). These beliefs frame assertions about the potential contribution of consistent enactment of political agency amongst frontline nurses. Therefore, political agency is understood as nurses’ recognition that they are entangled within a complex web of power and politics and they have a responsibility to choose how such political discourse will shape their practice. This choice is reflected in day-to-day micro moments of practice. Participants engaging with micro level politics worked to better balance the power imbalances between them and change decision-makers. Taking back power is an important demonstration of political agency.

It is note-worthy that political agency is not clearly defined in the nursing literature. A large volume of literature exists that indirectly addresses political agency and suggests how nurses ought to develop political agency (see works by Mason, Chinn, Buresh and Gordon), but the concept itself is not clearly defined. The meaning of political agency is assumed to be homogenously understood by the discipline of nursing, yet, without conceptual clarity a consensus cannot be determined. This lack of clarity contributes to the (in)consistency in mobilizing nurses as political agents in contemporary health care environments.

Participants in this study recognized that their work organization limited them from enacting what can be understood as political agency. These findings are not unique. Avolio (2014), Falk-Rafael (2005) and Varcoe and Rodney (2002) found that nurses working in multiple specialties and health care institutions experienced organizational constraints that prevented the enactment of political agency. What is important to note in this study's findings is that some (not all) nurses wanted to engage in political agency. Not doing so did not represent an apolitical will on behalf of nurses, but rather reflected constraints on enactment at the organizational level. According to Packard and Ferrara (1988) nursing is "by its very nature unavoidably political. Nursing struggles for, aims towards, knows about, and knows how to conduct right action, all of which is political and derives from the moral foundations of the very idea of nursing" (p. 65). Nursing is described as a political profession (Avolio, 2014; Buresh & Gordon, 2013; CNA, 2015; Harrison, 2011; Riot, 2002; Yoder-Wise, 2015), but it is recognized that where complex (and at times oppressive) relations of power exists, nurses struggle to enact political agency (Packard & Ferrara, 1998).

Caring in contemporary HCOs requires swift navigation of complex political landscapes, which makes caring a highly political act (Falk-Rafael, 2005). The growing gap described by participants between the care they were able to provide and the morally authentic care they wished for can perhaps be narrowed by nurses' purposefully exercising political agency. Political agency comes in many forms, yet nurses in this study conveyed understanding of political agency as large, public actions, such as "signing a petition" (participant 9, line 1492), "standing in front of a radio/television and saying loudly and clearly this will diminish patient care, this will diminish your nurses" (participant 9, line 1496-1498) or calling on elected officials to, "come in and look at our unit...see what is happening, watch us drown" (participant 11, line 348 -350). Interestingly, they did not seem to consider their day-to-day micro ethical actions of resistance, transgression and attempts at voicing as political acts. By way of political agency nurses are better able to fully enact their role as ethical subjects. As McMurray et al. (2010)

conclude: “in organizations the ethical subject is always a political subject” (p. 541). Evidence in the data suggests that nurses did not conceive themselves as political subjects or as being overly engaged in political acts. This requires a deeper examination of the disconnect that may exist between multiple understandings of politics within the nursing profession.

A factor that contributes to this disconnect is that nursing (both in the academy and in practice) tends to foster macro political discussion over micro political discussions. For example, in formal education, macro politics that govern the health care system are introduced, however developing the skills to be astute political agents remains largely absent in nursing curricula, in that “we do not encourage the widespread teaching of nursing and politics” (McKenna, 2010, p. 397). Nursing curricula focus on the construct of care, yet the understanding of caring as a political act requiring both political action and knowledge remains absent (Latimer, 2014). Discussing politics in nursing is largely uncomfortable (Perron. 2013; Perron et al., 2014). Alarming, a lack of political preparation carries forward into the workplace upon graduation. Research data shows that practicing nurses’ responses to organizational politics range from increased rates of reported burnout to quitting their current job, because politics are perceived to be a threat to nurses’ well-being (Basar & Basim, 2016). Lees (2016) articulates that nurses must be skilled at engaging with organizational politics when they “suspect their expertise or professional authority are being contested” (p. 742), as was reflected in participants’ experiences of rapid and continuous change.

Research found that working conditions for nurses in Canada are steadily on the decline as a result of managerialist minded leadership steering health care decision-making (Armstrong & Armstrong, 2003). Much blame for decision-making has been placed on macro level politics that are deemed unchallengeable, for instance, Ministry funding allocation. When such a position is taken, the discussion moves out of a personal ethical and political ethos because nurses perceive the problem as outside of their control. According to Lees (2016), during periods of fiscal restraint and depletion of resources in health care, it is imperative that nurses

engage with both power and politics.

Latimer (2014) suggests nurses request that patients be put first and foremost at all levels of the organizational hierarchy. Making such requests amidst multiple organizational complexities (fiscal restraint; ideological shifts) demands nurses' engagement with politics. The ability to exercise political agency in the face of adversity is a skillset, one that must be fostered across the discipline. Political agency is influenced by the organizations within which nurses' work, but it should not be dictated or defined by them. Although much of this dissertation turned a critical gaze outward onto HCOs, it also offers an opportunity to turn a critical gaze inward – to examine what nursing discourses and practices mean in the realm of politics.

The realities of nurses' work environments involve many elements of what has been described as the dark side of organizations (Linstead et al., 2014), including disqualified knowledge, feelings of voicelessness and powerlessness and the inability to practice elements of care of the self, including parrhesia. Navigating the dark side of organizations falls within the collective responsibility of nursing as a discipline. Nurses carry the burden of witnessing "the wasting away of care" (Armstrong & Armstrong, 2003, p. 1), but they must also carry part of the burden for finding ways to repair the shortcomings of the health care system. Nursing is not broken and in need of repair, but there is a need to overcome the uneasiness regarding the political nature of nursing and the profession's potential as a predominant political actor in a challenging health care context. Nursing can do this through its voice; nurses must cultivate their capacity to engage in politics and enact political agency in day-to-day micro ethical moments of practice.

The path to moral authenticity is a two-way street and requires meaningful engagement from both nurses and health care leadership. Nurses have an ethical commitment to provide "safe, competent, and ethical care" (CNA, 2008, p. 8), but doing so requires that collectively nurses and those who manage and lead health care institutions create care environments where ethical practice can be enacted and sustained. Packard and Ferrara (1998) suggest it is

erroneous to assume that forms of professionalization alone, for example, as embodied in professional codes of ethics, “is, or leads to moral authenticity” (p. 60). Providing safe, competent and ethical care requires leadership “support for ethical care” (Storch et al., 2002, p. 7), and also requires nurses to exercise “courage and commitment to voice moral concerns” (Storch et al., 2002, p. 7).

To voice is to engage in politics, something nurse participants in this study struggled to do. Political action was most often constructed outwardly, as being outside participants’ place of work, existing in the realm of citizen life (e. g., petitions, lobbying) as opposed to being embedded within organizational life. The concept of politics requires an altered understanding in front line nursing, and thus clinical practice. Nursing is inescapably political because it is relational (Perron, 2013). Rather than talking about politics as an extension of nursing work reserved for those nurses who are by nature politically minded, political awareness ought to be central to nursing practice. Nurses exercise political agency by using their voice in micro moments of their day-to-day work. They may use their voice to assert the value of the profession and the unique contributions made to health care. In doing so, they can make visible to others the multiple aspects of nursing work that are invisible in an era of increasing managerialism. Nurses may use their voice to articulate their multiple ways of knowing and their potential to uniquely contribute to organizational discourses and practices.

Returning to the thinking of Michel Foucault, in his addresses at the Collège de France, he suggests the concept of voice is deeply entangled within power/knowledge (Siisiäinen, 2012), building upon his fundamental thinking on the relations of power/knowledge (Foucault, 1980). Power/knowledge is deeply political (Foucault, 1980). The relationship between power/knowledge is understood as individuals or groups of individuals exercising power to instrumentally put forth certain forms of knowledge as truth claims. These truth claims shape individuals’ existence (the construction of self and thus self-worth/value), which carry forth into, and have implications on, their organizational lives. Voice may be a key way in which nurses’

can exercise power to move their knowledge from the margins of organizational discourses, for example, the discourses that inform rapid and continuous organizational change. Voice is an important concept in articulating nursing knowledge because it is the most common vehicle for articulating one's way of being in the world and the truths that inform the realities of day-to-day life (Gilligan, 1993). Voice is political and moral (Siisiäinen, 2012), and thus can be leveraged by nurses to rectify the disqualification of much nursing knowledge in organizational discourses, which may work in turn to minimize the occurrence of morally distressing situations.

Fleshing out the analysis and drawing a close to this discussion, and in keeping with the tenants of critical management studies, I suggest what is needed is both individual and organizational transformation (Alvesson & Deetz, 2000). Transformation is essential if health care is to move forward in ways that illuminate the political strengths and skills of all health care employees, not just management and leadership. When nurses engage in organizational relationships that foster political agency they play a pivotal role in creating and maintaining institutions that are ethical, morally habitable, and that exercise integrity.

### **Limitations**

Limitations reflect epistemological alignments and methodological decisions that impact the transferability of some aspects of this study. As noted in chapter 1, my own subjective experiences cannot be completely removed from the discussion presented here. My observations of repeated themes relating to organizational change implementation over a span of years inspired this project. Therefore, I chose to conduct a study wherein I was an insider (Evered & Lewis, 1981) researcher. The advantages and potential disadvantages of this choice are described at length in the methodology chapter. One potential disadvantage of all critical organizational research includes the potential for hyper critique (Alvesson & Deetz, 2000). This was mitigated in two ways. The utilization of member reflections during the data analysis phase of this study ensured accurate portrayals of participants experiences. Close teamwork with my academic supervisor and thesis committee resulted in the nuancing of data interpretations. My

thesis committee challenged me to account for what I was seeing and interpreting in the data, pushing me to explore beyond the confines of my own worldview. This provided a way to reflexively balance the influence of my past experiences, beliefs and values about the relationships between nurses and the organizations in which they work as they emerged in the data. This project allowed for a critical examination of organizational practices. The interpretations and conclusions drawn from this study are but one amongst multiple organizational perspectives and discourses.

One methodological decision that constitutes a limitation is the decision to collect data at only one site. This decision was made because an important guiding question of the study was conceptual exploration of an immature concept, change fatigue. Polit and Beck (2014) suggest that conceptual exploration should begin in one setting with a somewhat homogenous sample, and then can be expanded to include other settings and samples once more is known about the concept. It is now also the responsibility of the reader to consider if the knowledge generated with this study can help in better understanding other settings. Much of the literature integrated into both the literature review and discussion chapters validate key findings from this study. The findings have bridged concepts in new and meaningful ways that are transferable to multiple work environments as change is inevitable, and increasingly rapid and continuous in health care (Axelsson, 2000; Campbell, 2000) as organizations strive to adapt, improve and innovate in response to external pressures.

Another methodological decision that can constitute a limitation was the use of interviews as the sole method of data collection. As with all inquiry (both qualitative and quantitative), the researcher cannot guarantee that participants provided exact portrayals of their experiences. Consistent with my epistemological stance, care was taken to facilitate open sharing of personal accounts, and as such, these are considered to be reliable and as reflecting participants' views at the time and place of data collection; however, it is understood that these views may shift. As Monahan and Fisher (2010) argue, data is subjected to "interpretation and

reinterpretation; it is too simplistic to think of some data as true and others as false” (p. 371).

While the study specifically recruited frontline nurses working shiftwork, many participants had previously held other roles such as clinical managers and charge nurses within the institution at varying points in time. This offered additional richness and depth to the data facilitating thick description as participants conveyed experiences shaped by various organizational perspectives.

Another potential limitation is that it is likely that a particular subset of the collective “we” may have been drawn to this study, those who had strong opinions and feelings regarding rapid and continuous organizational change, who came forward to share their experiences. There may have been nurses in this particular setting who took no particular issue with the rapid and continuous change initiatives that had taken place, whose experiences were not captured in this study. As a result, some of the themes that emerged from the data may not reflect their experiences. While participants generalized their experiences, it would be erroneous to assume that their narratives necessarily capture those of all nurses in the setting.

### **Implications for Nursing**

Nursing practice, as noted throughout this dissertation, is profoundly impacted by rapid and continuous change in health care. The role of nurses and their practice amidst shifting ideologies that support a culture of service over a culture of care must be reflected upon, as themes of deskilling and devaluing were vividly present in participants’ narratives. Collectively, as a discipline nursing needs to clearly articulate its role in health care amidst these changing landscapes, ensuring that integrity and professional identity shape the construction of that nursing role. The relational dimensions of nursing needs to be prioritized, and there needs to be serious consideration of the ways certain hallmarks of modern care (e.g., technology) impact care relations. To stand firm on those values that shape nursing’s role requires that nurses utilize both macro and micro-ethical moments to engage in acts that are political.

## Practice and Education

Much rich data can be discussed in terms of practice implications, both for nurses and leadership (as individual and groups). Suggestions for both at micro, meso and macro levels are presented below. At the micro-level, it is imperative that nurses learn to use their voice in a field of competing discourses; nurses must master the games of truth. Using their voice in a way that ensures they are heard and understood by leadership involves learning how to communicate in ways that can be understood outside of nursing-specific discourse. For example, lamenting the loss of time to “cuddle babies” (participant 5, line 172) is ineffective in gaining epistemic legitimacy. Articulating the important care activities that are carried out during that time, alongside the evidence-based benefits of such therapeutic interventions, is more effective in gaining epistemic legitimacy. Nurses must also take the initiative to become more aware of what is happening within their workplace. Multiple participants remarked on the existence of committees responsible for change initiatives, and that they knew of, or had once been, nurses on such committees. Yet, the widespread dissemination of that information from involved nursing members to frontline staff was not discussed. It is important to consider ways in which individuals can be taught and supported in the art of solicitation, so then to language that information on their colleagues’ behalf at these types of meetings. Micro-level political action is important, as participant 7 reminds us: “politics are involved everywhere [in healthcare] and you [nurses] must be mindful of that” (line 255). This is a philosophical shift for many, and will require acceptance from administrators and perseverance from nurses.

At the meso-level of the nursing profession, professional organizations can help the individual nurse find a voice and use that voice within a larger group. This may be achieved through multiple platforms, such as small groups created through local chapters, larger conferences, or continuing education courses. It is vital that nurses gain skills to effectively lobby for the resources they need to provide nursing care that upholds their moral imperative and supports a culture of care. Professional organizations have the opportunity to make

significant contributions at a macro-level by helping nurses learn to speak about nursing issues to local politicians. Nurses need support learning how to frame a particular situation into a more conceptual issue that is happening everywhere. This will ensure that politicians better understand the magnitude of their concerns. Currently, professional organizations such as the RNAO develop many policy letters regarding pressing health care issues that are available for nurses to distribute to local politicians. This is an important contribution to nursing's political voice, but nurses should be at the forefront of such movements by writing the letters themselves, balancing both relevant literature with lived experience.

Future macro-level political agency in the discipline of nursing could be achieved by nurses in clinical practice fostering the creation of health care technologies. This would help ensure that health care technologies more strongly support nurses in their day-to-day practice and facilitate the acts of caring. Many participants discussed the lack of intuition in software and technological design, noting this was often what took their time away. A remedy is to position nurses within teams that develop health care technology, so that it is properly adapted to nurses' ways of working and allows full use of their critical thinking skills should technological problems arise. This notion is supported by Androwich (2013) and Sensemeier (2011), who suggest that current technological disruptions to nursing work are an opportunity for nurses to take the lead in health care technology design.

Current nursing informatics literature, however, argues that nurses must be taught how to use technological systems as opposed to designing them. And doing so will alleviate many nurses' concerns and frustrations (Button, Harrington & Belan, 2013; Darvish et al., 2014; Norton, Skiba & Bowman, 2006). This argument is fundamentally flawed because it assumes that technology is always appropriate for, and compatible with, nursing practice. These notions contradict the findings from this study, where technology impeded nursing practice. Nurses can embed themselves in health care technology discourse by taking part in local and global hackathons organized by global information technology developers in partnership with health

minded organizations. These events are opportunities for multiple health care stakeholders to share their vision of what technology in health care should and could look like and to work alongside others to design intuitive technology. Positioning nursing in non-traditional nursing roles such as information technology can constitute a political act.

The perspectives of administration also require reconfiguration. As multiple participants noted, “it can’t be all about the money” (participant 5, line 520). Leadership must critically evaluate the purpose and merit of change, and health policy should be developed in ways that acknowledge the instrumental role of health care providers in enacting health policy. Participants suggested a lot of ways that leadership could better engage and support nurses through change initiatives. First and foremost, communication styles of leadership require reconsideration. Autocratic styles of leadership and the associated bullying behavior described by participants are not acceptable. Such communication styles silence nurses and oppress their attempts at political action.

At the micro level, the ongoing management of change initiatives requires rethinking. Initiatives such as Lean were initially effective at enabling nurses’ involvement in unit level decision-making. Some participants felt they had a voice and were able to contribute to effective solutions. Their involvement was a way for nurses to engage in a political act. However, the expectations of nurses’ involvement began to grow exponentially while resources were simultaneously declining. For change initiatives to be successful, ongoing resources and supports are needed. Associated maintenance costs should be included in the planning stages and transparently communicated to nurses. The same concerns emerged from participants discussing the expert user role. Nurses supported the philosophy behind expert users, deeming it necessary to ensure successful change implementation. Resources to ensure the role of expert user would be safe-guarded were often unavailable, thus the role of the expert user was rendered ineffective.

At a macro level, participants suggested change initiatives required a more critical analysis before decisions were made. For example, concretely articulating to all staff exactly how changes will enhance patient care, and support the delivery of care. Participants felt they were often given vague information regarding change initiatives that did not enable them to be active participants in the decision-making process. If, after given such information, frontline health care providers raise significant concerns, these should be flushed out and re-evaluated by leadership, as participants often accurately foreshadowed the negative impacts of change initiatives. Sustainability efforts need to be better planned, developed and communicated to frontline staff that ensure change initiatives will be supported for months and years to come. Additionally, participants provided insight into how the implementation phases of change initiatives could be improved. Hospital wide rollouts should be avoided. Instead, rollouts should be done in smaller increments, with the first several units used as beta testing. Such a strategy would ensure increased ease in managing the impact of the multiple kinks reported in hospital wide rollouts. Associated negative impacts would not be as far reaching as with hospital wide rollouts. Smaller increment rollouts would allow staff to become more confident and comfortable with changes. Expert users could be selected from that beta sample user group, as they would have real clinical experiential learning. They could improve the training sessions and then train subsequent users in the next phase of the rollout. Smaller rollouts can ensure that each group is more involved in the decisions about the timing of rollouts, required training and required length of expert user support.

The either/or narrative that emerged requires attention. Compromise on behalf of both nurses and leadership regarding change initiatives was scarce. It may be fruitful to revisit this dissonance and prescribe pragmatic solutions. For example, the standardization practices described by participants were implemented in ways that left nurses feeling deskilled and their knowledge devalued. Leadership penalized non-adherence to standardized practices. An approach that better supports a culture of care would be to inquire what elements of

standardized practices did not coincide with nursing knowledge and associated workflow. Further, the uniqueness of each practice area and associated patient needs, should receive consideration when evaluating the appropriateness of hospital-wide standardization practices. Small unit based adaptations could go a long way in balancing nursing autonomy and the standardization of care activities.

Political agency must become the norm. Normalizing nurses as political agents begins in formal training at the undergraduate level. Politics is a core concept that needs to be embedded into curricula in multifaceted ways as opposed to classes dedicated only to politics (Avolio, 2014). In addition, politics must be introduced early in training (Mueller, 2015; Yoder-Wise, 2015). Introducing politics towards the end of formal training is problematic because much socialization into the discipline has already occurred. Nursing students begin to see organizational politics early in their training and require the knowledge and skill development to recognize and navigate politics in both lecture and clinical settings. Rains and Barton-Kreise (2001) report study findings suggesting student nurses do not see a connection between the “personal, professional and political” (p. 219). The actualization of nurses as political agents requires “faculty modeling of political competence and opportunities for students to realize personal, professional and political connections” (Rains & Barton-Kreise, 2001, p. 219). These opportunities may be provided through the cultivation of voice by both students and faculty. As noted previously, voice is political, therefore fitting to use as a catalyst for political realization. Faculty may use their voice to create a space where students feel empowered to engage with political discourse, and can develop political agency skills. Outside of the classroom, political agency must also be promulgated in clinical settings. This begins with the recognition that nursing is political, and that political agency is a required component of care, not unlike other widely acceptable components of care, for example, medication administration or routine patient assessments. The ways in which political action is understood must also shift. As noted previously, a disproportionate amount of political understanding in nursing reflects macro-levels

of political action. This was demonstrated in the data by participant's understandings of "being political" (participant 9, line 1485) that included "protesting" (participant 9, line 1414), "signing petitions" (participant 9, line 1415), "and going to the [local government]" (participant 11, line 348).

## **Policy**

Policy development strategies should include positioning nursing expertise within organizational change discourses to examine the potential impact on nurses. Nurses made multiple recommendations on how to support nurses better through change initiatives. Recommendations included asking the end-users (nurses), listening, slowing down change implementation, implementing less changes at once, and accommodate nurses throughout the change process. An example of accommodating nurses that had potential to better support nurses was the use of just in time education. Just in time education "is based on the concept that learning is facilitated when education is provided in a time-sensitive manner (i.e., education delivered at the moment it is most needed)" (Kent, 2010, p. 2). Just in time education provided by the institution fell short because, in the examples provided by participants, it did not occur when was most needed by nurses, but rather when it was convenient for trainers and educators to provide it. All examples participants provided illustrate how to integrate nurses into change processes. If organizations apply these recommendations nurses will engage in meaningful ways. Incorporating their knowledge and expertise into change management may alleviate many of the challenges highlighted in this study, including elements of change fatigue and moral distress. If nurses are engaged in change process in meaningful and significant ways, change initiatives could more strongly support a culture of care. This may alleviate some of the moral distress nurses experienced as a result of rapid and continuous changes that supported a culture of service. Institutions can uphold and align its integrity, moral obligations and actions by integrating nurses into the change process.

Findings from this study highlight the complexity of organizational life when the human components of change are considered and bring to light multiple opportunities for future nursing research, with a focus on the human complexity of organizational life as it relates to HCOs.

### **Research**

It is imperative to re-iterate the importance of nursing research that focuses on frontline nurses as participants because they are marginalized in many aspects of contemporary health care (Buresh & Gordon, 2013; Rankin & Campbell, 2006). Questioning taken-for-granted institutional discourse pertaining to quality care reveals competing truths that profoundly impact the ways in which nursing work is constructed and enacted. Critical research is of paramount importance in such endeavors, offering tools to examine and challenge the status quo. Using multiple avenues to disseminate findings disrupt the status quo and mobilizes marginalized groups and discourses.

Fifteen years ago a Canadian study by Dunleavy, Shamian and Thomson (2003) found that restructuring in Ontario had negative impacts on health care staff workloads, and that patients were suffering as cutbacks created chaos in care and interruptions to care delivery. Over a decade later, this dissertation reports similar findings in a tertiary care facility where ongoing change initiatives have resulted most notably from restructuring efforts. This appears to be a fairly clear testament that managerial decision-makers within HCOs do not hear the voices nor implement knowledge and research findings of either frontline nurses or researchers who study nursing work. The implications at all levels of decision-making are far reaching for nurses and patients. Nurses continue to experience significant levels of exhaustion and burnout amidst shifting organizational ideologies and priorities, and feel silenced and de-valued in their practice. In particular, moral distress has repeatedly been acknowledged as a pressing concern requiring immediate attention (Bernadette, Varcoe & Storch, 2012); however a purported lack of conceptual clarity as to the “underpinnings of moral distress” (p. 1) is often construed as an impediment to assertive action aimed at alleviating moral distress.

Nurses in practice and academia, as well as organizational and health service researchers collectively must reconsider what constitutes ethical health care organizations. Future research should explore the construction of what are and are not ethical HCOs from the perspectives of frontline staff. Decision-making plays an important role in organizational integrity regarding who makes decisions and to what end. Boyle and colleagues (2001) articulate the importance of exploring decision-making processes in evaluating ethical integrity and suggest three ways in which to do so that may be useful in informing future organizational research endeavors.

First, Boyle and colleagues (2001) recommend the observation of behaviors that inform organizational decision-making. Such observations can be carried out during committee meetings and other situations where organizational decisions are routinely made. The following questions should guide the researcher in such inquisition: "How do relationships of power and authority influence the decisions made by subordinates and superordinate's? What are the operative decision rules? Do they systematically lead to ethically questionable outcomes?" (Boyle et al., 2001, p. 50). This organizational research could be done through the use of ethnographic inquiry. Ethnography comes from anthropology, a field of study rooted in cultural analysis that understands experience as socially mediated and contextually embedded. For the purpose of future organizational research, both institutional and focused ethnography could be used. Institutional ethnography (Smith, 2006) would facilitate a broad cultural and contextual analysis of all actors involved in routine organizational decision-making. A distinguishing characteristic of ethnography is the amount of *time* the researcher spends doing fieldwork. Fieldwork here means a prolonged process of engagement between the researcher and the setting to decipher underlying meanings behind study participants' experiences and behavior. Focused ethnography would facilitate a cultural and contextual analysis of specific groups of actors within decision-making processes, which could include frontline nurses, nurse managers, or other groups of frontline or leadership staff. This research method applies ethnographic logic

to a specific focus area, allowing researchers to “conduct research on a small group as opposed to an entire cultural system” (Chan, 2014, p. 42). A focused ethnography could be used to explore how nurses do or do not articulate their counter narrative to disrupt the games of truth. As previously noted, nurses contributed to a counter narrative in the context of a confidential interview space, but whether that practice transpires into the workplace, and in what capacity, remains unknown.

In addition to Boyle’s suggestions, it would be beneficial to explore how micro-level decisions are made by nurses to better understand how time is allocated, and subsequently reallocated as a result of change initiatives. Time-in-motion studies (Lopetegui et al., 2014) would be an appropriate method to understand and document how time is reallocated with particular change initiatives. Time in motion studies emerged as important methods to better understand and enhance workflow (Gilbreth, 1914). Contemporary healthcare researchers use time in motion studies to explore the relationship between workflow and efficiency (Chaudry et al., 2006; Poissant, Pereira, Tamblyn & Kawasumi, 2005; Silow-Caroll, Edwards & Rodin, 2012).

Studies that employ a think aloud technique (Fonteyn & Fisher, 1995; van Someren, Barnard, & Sandberg, 1994) would help comprehend cognitive processes associated with adapting to change initiatives. Think aloud research techniques facilitate a better understanding of thinking processes associated with decision-making, which can be difficult to articulate to non-experts in the area of study (van Someren et al., 1994). This type of research is especially important in light of findings from this study that suggest nurses are not always successful in communicating the importance of their work to those outside of nursing. It is important to understand how new technologies facilitate or hinder nurses cognitive processes, as many of nurses express their concerns in vague terms for instance suggesting that workflow resulting from change initiatives “just takes longer” (participant 2, line 526; participant 10, line 219; participant 12, line 193).

Second, Boyle and colleagues (2001) recommend that organizational members should be interviewed. Organizational members should be asked why and how they make decisions, and in what ways they establish and negotiate priorities (both with the self and with others). In addition, Boyle et al. (2001) suggest to “ask members what motivates decision making. Ask how pressure from the top influences what and how decisions are made” (p. 50). This study incorporated questions regarding decision making during interviews (see appendix G). This generated data describing recurrent lack of involvement in decision-making resulting in feelings of powerlessness and negative attitudes towards the organizational actors who made decisions. Further questioning regarding motives and internal and external pressures would provide a better understanding of how relations of power mediate important health care decision-making. Furthermore, to expand understanding beyond the scope of a sole discipline, a case study approach could be utilized. Individual interviews and focus groups with key stakeholders, such as representatives from health care funding bodies, leadership staff, frontline staff and members of the public, could provide rich data regarding the complexity of health care decision-making.

The focal point of this dissertation was frontline nurses, but this is only one of many perspectives. As participants noted, they did not always understand their managers’ rationale for decision-making yet empathized with the challenges of nurse managers. Critical management studies, the chosen theoretical framework that has guided this study, has often been critiqued for its othering of management, identifying managers as nothing more than a function of their place within an organizational hierarchy (Wray-Bliss, 2009). Managers are, as seen at times in the data and as described by Wray-Bliss (2009), moral subjects of their own actions, who, due to the nature of organizational hierarchies and bureaucracies, find themselves “invariably saturated with uncertainty, ethical pluralism and the multiple constituting and conflicting webs of power” (Baumann, 1993, p. 248). Managers in particular are at the intersect of multiple, and often competing priorities, imperatives, and requirements. The ways in which managers experience organizational change is also of interest as it could offer profound insight

into the growing disconnect between frontline nurses and leadership, noting both parties appear to be mediated through nurse managers.

Third, Boyle and colleagues (2001) suggest the examination of organizational documents. Documents should include the procedures that inform organizational decision-making and may also include general operational procedures. These documents should be compared to either first hand encounters of decision-making processes (ethnography) or second hand accounts (interviews or focus groups). Organizational document analysis could be achieved through the use of critical discourse analysis. Discourse analysis stems from sociolinguistics and examines the forms and rules of conversation (Polit & Beck, 2010), "In discourse analysis texts are situated in their social, cultural, political, and historical context." (p. 264). According to critical management scholars, critical discourse analysis in organizations turns specific analytical attention to social interactions whilst remaining sensitized to the taken-for-granted, including the normalization of certain organizational processes, marginalizing practices and the naturalization of certain routines and practices (Alvesson & Kärreman, 2011). Critical discourse analysis in organizations "makes it possible to focus on and highlight everyday and routine organizational activity such as conversations and other forms of propagating talk and text" (Alvesson & Kärreman, 2011, p. 1123), therefore making it an appropriate methodology for the analysis of documents in HCOs that may help understand how every day and routine activities can shape the dark side of organizations.

A supplementary discourse analysis of hospital artifacts, for example those described by participants (posters, corporate slogan signage, media press releases), could examine the dissonance between formal institutional discourse regarding excellence in care and nurses lived experiences. Additional documents could include various meeting meetings where change initiative are discussed and where decisions regarding change initiatives are made. Meeting minutes would provide information about who regularly attends, how much time is allotted to specific items and what type of language is used in the meetings. Meeting minutes would note

the time and place of meeting, offering insight into potential exclusionary practices. Is the time and place conducive to nurses' attendance? Is there equal representation of nurses in comparison to other members of the interdisciplinary team?

Documents could include hospital websites (both intranet and internet), corporate postings and signage throughout the hospital, publically articulated mission statements and value assertions, and organizational communications to both staff and the public. Analyzing such artifacts would facilitate an in depth understanding of certain phenomena described in this study, including communications regarding decision-making, deskilling practices and the corporatization of care. Examining the strategic use of corporate branding mechanisms would prove useful in understanding ways in which nurses may be instrumentalized towards what one participant identified as "propaganda" (participant 3, line 488) in their day to day work. Such examination could flesh out nurses' discomfort and, at times, fear of speaking out against corporate branding and propaganda, in light of the way "claims of promoting excellence in service delivery have made it very difficult for any group to counter managerial logic" (Gilbert, 2005, p. 455). This type of analysis would facilitate an in depth understanding of strategies used to corporatize nursing work, the (re)configuration of power relationships involved in this process, as well as the mobilization, or lack thereof, of nurses' knowledge, experiences and discourses. The emergent discrepancies and incongruences may challenge us to reconsider and re-evaluate what constitutes ethical HCOs.

### **Concluding Remarks**

In closing, I hope that at times this dissertation brought you, to a place of discomfort about the current state of nursing work. I hope that participants' voices resonated with you in ways that evoked some form of emotion challenging you to think alternatively about the realities of nurses' day-to-day lives. I strived to create a space where the voices of nurses could stimulate others to re-examine the increasing complexities and challenges that contemporary HCOs create for frontline nurses. It is time we, both within and beyond the discipline of nursing,

turn our attention to the difficult realities of nurses working in contemporary HCOs. It is important to challenge managerial ideologies that are harming nurses and patients. Participants highlighted that the many issues brought forth in this dissertation need to be news for more than just a day. They deserve to be more than just an article in a union or professional magazine that, at best, a handful of academics or practitioners read. These issues need to be put forth in political ways that move nursing's project forward - to provide quality nursing care in environments that support them. To do this, nursing's collective knowledge as articulated through nurses' experiences must be communicated in raw ways that challenge individuals to think differently about the state of affairs within the confines of HCOs. Nurses live within the dark side of organizations day in and day out, and it is time that their experiences be publicly shared, and that the fear of reprimand be put to rest.

When nurses move their discourse from the margins to the center of organizational discourses they will be able to practice within a moral framework that is ethically congruent with the self, and which can alleviate much moral distress (Pavlish et al., 2012). The ability to articulate one's voice in ways that work to attain moral authenticity in nursing practice can be understood as an important technology of the self. To voice, nurses must not only problematize their relationships with multiple others (technology, leadership, patients), but must also problematize the relationship to the self, and work to transform that relationship in ways that are both morally and ethically authentic. Voice may be used as an instrument to care for the self (Foucault, 1977). Nurses may truly (re)claim their practice by learning how to garner and utilize voice in ways that bring about their moral authenticity and as a means to political action.

The ethical subject is always a political subject; the one who takes action in response to the call of the ethical demand. It is answering the call to political action by the ethical subject—a subject prepared to act in response to the experience of injustice while not resting easy on their own ethical righteousness—that provides an affirmative possibility for researching and theorizing ethics within a critical framework (McMurray, Pullen, & Rhodes, 2010).

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## Appendix A



RESEARCH INSTITUTE  
INSTITUT DE RECHERCHE

## CHEO Research Ethics Board Approval - Delegated Review

**Principal Investigator:** Dr. Judy Rashotte

**REB Protocol No:** 14/174X

**Romeo File No:** 20140485

**Project Title:** CHEOREB#14/174X - A critical hermeneutic study of pediatric nurses' experiences within the processes

of rapid and continuous organizational change

**Primary Affiliation:** Clinical Research\Nursing

**Protocol Status:** Active

**Approval Date:** November 17, 2014

**Valid Until:** November 15, 2015

**Annual Renewal Submission Deadline:** 15 October 2015

### Documents Reviewed & Approved:

Document Name	Comments	Version Date
Protocol	Research Protocol	2014/10/07
Recruitment Materials	Recruitment poster Version 2	2014/11/09
Consent Form	Consent form version 2	2014/11/09
Questionnaire/Survey	Socio-demographic questionnaire Version 2	2014/11/09
Recruitment Materials	Recruitment email Version 2	2014/11/09

The REB is waiving the requirement for French translation of the approved documents for the aforementioned study.

This is to notify you that the Children's Hospital of Eastern Ontario Research Ethics Board has granted approval to the above named research study on the date noted above. Your project was reviewed under the delegated review stream, which is reserved for projects that involve no more than minimal risk to human subjects. Final approval is granted for the above noted study, with the understanding that the investigator agrees to comply with the following requirements:

1. The investigator must conduct the study in compliance with the protocol and any additional conditions set out by the Board.
2. The investigator must not implement any deviation from, or changes to, the protocol without the approval of the REB, or when the change involves only logistical or administrative aspects of the

- study (e.g., change of telephone number or research staff).
3. The investigator must, prior to use, submit to the Board changes to the study documentation, e.g., changes to the informed consent letters, recruitment materials.
  4. For all other research studies, investigators must promptly report to the REB all unexpected and untoward occurrences (including the loss or theft of study data and other such privacy breaches).
  5. Investigators must submit an annual renewal report to the REB 30 days prior to the expiration date stated above.
  6. Investigators must submit a final report at the conclusion of the study.
  7. Investigators must provide the Board with French versions of the consent form, unless a waiver has been granted.

For complete procedures relating to REB procedures, please refer to the REB website at <http://www.cheori.org/en/researchethicsboard> or contact Natalie Anderson at [nanderson@cheo.on.ca](mailto:nanderson@cheo.on.ca) or 613-737-7600 ext. 3350.

Regards,

Dr. Carole Gentile  
Chair, Research Ethics Board  
Présidente, Comité d'éthique de la recherche  
401 Smyth Road, Ottawa, ON K1H 8L1  
Tel: (613) 737-7600 ext. 3624 | Fax/Téléc: (613) 738-4202 | [gentile@cheo.on.ca](mailto:gentile@cheo.on.ca)

## Appendix B



## Université d'Ottawa University of Ottawa

Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

November 25<sup>th</sup>, 2014

Kim McMillan  
 Doctoral Student  
 School of Nursing  
 Faculty of Health Sciences  
 University of Ottawa

Amélie Perron  
 Professor/Supervisor  
 School of Nursing  
 Faculty of Health Sciences  
 University of Ottawa

**Co-Investigators:** Judy Rashotte, Site investigator, CHEO

**Re: U of O Ethics file no. A11-14-07 – “A critical hermeneutic study of pediatric nurses’ experiences within the processes of rapid and continuous organizational change”**

Dear Ms. McMillan, Professor Perron and Dr. Rashotte,

Thank you for the protocol documents and Certificate of Approval from the CHEO REB (# 14/174X) for your project named above.

This is to confirm that, in accordance with the agreement between the University of Ottawa and CHEO REB, the University of Ottawa has authorized this board to act as Board of Record for the review and oversight of research involving human subjects conducted at or through the hospital.

We remind you of your obligation to:

- Follow all procedures of the CHEO REB including reporting and renewal procedures;
- Submit to the authority of the CHEO REB and that you are subject to CHEO REB requirements, including, without limitation, the requirement to modify or stop the research on demand of the CHEO REB.

If you have any questions, please contact our ethics office at 562-5387.

Sincerely yours,  
 Catherine Paquet  
 Director

Office of Research Ethics and Integrity

550, rue Cumberland 550 Cumberland Street  
 Ottawa (Ontario) K1N 6N5 Canada Ottawa, Ontario K1N 6N5 Canada  
 (613) 562-5387. Telec./Fax (613) 562-5338

<http://www.recherche.uottawa.ca/deontologie>

<http://www.research.uottawa.ca/ethi>

## Appendix C



# Calling All Nurses:

Pediatric nurses' experiences within the processes of rapid and continuous organizational change

## To Take Part In This Study

### You Must Be:

A frontline registered nurse working shiftwork on any of the following inpatient units: Emergency, PICU, NICU, 4E/W, 4N and 5E

**AND**

Have worked at CHEO for at least one year

**AND**

comfortable in sharing your experiences in English

### For more information, interested participants may contact:

**Kim McMillan, RN, BScN, PhD (c)**  
Principle Investigator  
kcmillan@cheo.on.ca

#### Research Team:

**Kim McMillan, RN, BScN, PhD (c)**  
Principle Investigator  
University of Ottawa  
kcmillan@cheo.on.ca

**Dr. Judy Rashotte**  
Principal Site Investigator  
Director Nursing Research, CHEO  
613-737-7600 ext. 3348

**Dr. Amélie Perron**  
School of Nursing  
Faculty of Health Sciences  
University of Ottawa

**Dr. Sarah Wall**  
School of Nursing  
Faculty of Health Sciences  
University of Alberta

This research project has been approved by the Children's Hospital of Eastern Ontario's Research Ethics Board



Version Date: November 9, 2014

## Purpose of the Study:

Change in health care has become rapid and continuous as health care institutions strive to meet the ever changing needs of the patient populations they serve. Rapid and continuous changes greatly impact frontline nurses, however little research is available on how nurses are experiencing such changes in their workplaces. The aim of the proposed study is to explore the nature of frontline pediatric nurses' experiences of living with rapid, ongoing organizational change in a tertiary-care health institution.

## Your Participation Would Involve:

During an audio-taped, conversational-type interview, you would be asked to speak about your experiences of rapid and continuous organizational changes at CHEO. The interview will be conducted by a doctoral candidate from the University of Ottawa, will last about 1 to 1 ½ hours, and will take place at a place and time convenient to you. The interview process is scheduled for December, 2014 – April, 2015.

## What this study will accomplish:

By focusing on how nurses experience rapid and continuous change, we hope that there will be an increased understanding of how nurses uniquely experience change. Nurses may provide innovative and novel ideas about change that are timely and relevant as health care organizations become more complex and dynamic in their efforts to accommodate changing patient and population needs. Nursing knowledge can offer valuable insight in understanding both the complexities and possibilities of health care organizations.

## Appendix D

Dear nursing colleagues,

You are invited to participate in a research project approved by the Children's Hospital of Eastern Ontario's Research Ethics Board. The research project is being conducted by myself, Kim McMillan, a doctoral candidate enrolled in the University of Ottawa School of Nursing doctoral program. The purpose of the study is to explore pediatric nurses' experiences of rapid and continuous organizational change in their workplaces. This study will focus on frontline nursing staff. You are considered a frontline nurse if you provide patient care at CHEO working through shifts of days, evenings, nights and weekends on any of the follow acute care inpatient units: Emergency, PICU, NICU, 4E/W, 4N and 5E. I am recruiting Registered Nurses who have worked at CHEO for at least one year.

Your participation will consist of one private interview with the myself, the principal researcher. During this interview you will be asked to discuss your perceptions and experiences with change in your workplace. The interview will last between 60 and 90 minutes and will take place when you are not working on the unit, depending on your availability. It will be held in a confidential location agreed upon by you and myself. The interview will be digitally recorded unless you refuse (in which case hand-written notes will be taken). The recorded interview will be transcribed by myself, after which it will be deleted. All identifying information mentioned during the interview (e.g. names of administrators, managers, staff or the hospital) will be eliminated from the transcript. A random code will be used instead of your name. You will also be invited to provide feedback about the analysis to ensure an accurate and just portrayal of your experience. This opportunity will occur prior to any dissemination of study results.

I have attached a more detailed information sheet. If you are interested in participating please feel free to contact me at:

[kmcmillan@cheo.on.ca](mailto:kmcmillan@cheo.on.ca)

Thank you for your time and consideration,

Kim McMillan, RN, BScN, PhD (c)

## Appendix E

**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.

Code: \_\_\_\_\_

Female  Male

Age:

- 30 years old and under   
 31-40 years old   
 41-50 years old   
 Over 50 years old

Current practice setting:

- Acute care (inpatient pediatrics)   
 Critical care (Emergency, ICU, NICU)   
 Other   
 Please identify \_\_\_\_\_

Training (please select all that apply):

- Hospital/College diploma   
 University undergraduate degree   
 Please identify \_\_\_\_\_  
 Postgraduate degree (masters)   
 Please identify \_\_\_\_\_  
 Other certifications   
 Please identify \_\_\_\_\_

How long (months, years) have you worked at CHEO: \_\_\_\_\_

How long (months/years) have you worked on your current unit: \_\_\_\_\_

In the past 12 months have you considered leaving your position: \_\_\_\_\_

In the past 12 months have you considered leaving the nursing profession: \_\_\_\_\_

Are you currently actively seeking employment elsewhere: \_\_\_\_\_

## Appendix F



### Information Sheet and Consent Form

#### Investigators:

Kim McMillan, RN, PhD(cand)  
 School of Nursing  
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Judy Rashotte, RN, PhD (CHEO P.I.)  
 Director, Nursing Research &  
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 Children's Hospital of Eastern Ontario

Sarah Wall, RN BScN MHSA PhD  
 School of Nursing  
 Faculty of Health Sciences  
 University of Alberta  
[swall@ualberta.ca](mailto:swall@ualberta.ca)

**Title:** A critical hermeneutic study of pediatric nurses' experiences within the processes of rapid and continuous organizational change.

#### Invitation to participate

You are invited to participate in the above-mentioned study conducted by myself, Kim McMillan, a doctoral candidate enrolled in the School of Nursing doctoral program, and my thesis supervisor, Dr. Amélie Perron. You are being asked to participate because you are a frontline registered nurse working shiftwork (days/nights and/or evenings) on any of the following inpatient units: Emergency, PICU, NICU, 4E/W, 4N and 5E and must have worked at CHEO for at least one year.

#### Why is the study being done?

The purpose of this doctoral research is to explore: 1) How are nurses experiencing organizational change? 2) How do changes in the workplace support and/or disrupt the way nurses carry out their work?  
 3) Is there evidence of change fatigue in nurses' discourse about change? 4) Do perceived levels of power in the process of change impact nurses' experiences with change?

#### How many people will take part in this study?

10-20 frontline registered nurses will take part in this study. You are considered a frontline nurse if you provide patient care at CHEO working through shifts of days, evenings, nights and weekends on any of the follow acute care inpatient units: Emergency, PICU, NICU, 4E/W, 4N and 5E. I am recruiting registered nurses who have worked at CHEO for at least one year.

### **Nature of your participation**

Your participation will consist of one private interview with the principal researcher. During this interview you will be asked to discuss your perceptions and experiences with change in your workplace and fill out a short socio-demographic questionnaire (2 minutes). The interview will last between 60 and 90 minutes and will take place when you are not working on the unit, depending on your availability. It will be held in a confidential location agreed upon by you and myself. It will be digitally recorded unless you decline (in which case hand-written notes will be taken). The recorded interview will be transcribed by the principal researcher, after which it will be deleted. All identifying information mentioned during the interview (e.g. names of administrators, managers, staff or the hospital) will be eliminated from the transcript. A random code will be used instead of your name. You will also be invited to provide feedback about the analysis to ensure an accurate and just portrayal of your experience, prior to any dissemination of study results.

### **What are the risks of participating in this study?**

You may find it emotionally difficult to discuss some of your experiences with regards to change in your workplace. 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 will be assisted you in reaching your employee assistance program. The information you provide will be confidential and de-identified. It will not be used to assess your performance at work. It will not impact your relationship with your employer in any way.

### **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 change process in your workplace. It will also serve to raise awareness about nurses' experiences with and concerns towards continuous organizational change.

### **What about Confidentiality and Privacy?**

The information you share will remain strictly confidential except as required or permitted by law. It will only be used for the purpose of this study. Access to the research data will be limited to the principal researcher and her research committee. A random code will be used to identify your interview transcript and questionnaire. During the transcription of the interview, all names mentioned in the course of the interview (persons, hospitals, cities, etc.) will be eliminated. Once interviews are transcribed the recordings will be immediately deleted. The research data (consent forms, interview transcripts, socio-demographic questionnaire) will be securely stored in a locked filing cabinet in the thesis supervisors locked private office at the University of Ottawa. The research data will be kept for 7 years, until June 2021. After this time, all data will be 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 course. In all cases, you and the hospital will not be identified. When needed, the random code you were assigned will be used.

### **If I chose, how would I withdraw from the study?**

You are under no obligation to participate in this study. Your decision will not affect in any way your employment or your relationship with your employer. You may withdraw from the study at any time without justifying your decision. Your signature on this form indicates that you understand the information in this consent form and that you agree to participate.

By signing this form, you are not waiving your legal rights as an employee and 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 researchers at any time regarding this study and your participation. This research was approved by CHEO Research Ethics Board and 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](mailto:ethics@uottawa.ca).

The CHEO Research Ethics Board (REB) has reviewed and approved this research project. The REB is a committee of the hospital that includes individuals from different professional backgrounds. The Board reviews all research that takes place at the hospital. Its goal is to ensure the protection of the rights and welfare of people participating in research. The Board's work is not intended to replace a parent or child's judgment about what decisions and choices are best for them. You may contact the Chair of the Research Ethics Board, for information regarding patient's rights in research studies at (613) 737-7600 (3272), although this person cannot provide any health-related information about the study.

### 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

I wish to provide feedback of my interview during the researcher's data analysis: Yes  No

Correspondence regarding feedback may be directed to the following email address: \_\_\_\_\_

I agree to participate in this study. There are 2 copies of this consent form, one of which is mine to keep.

Participant's signature: \_\_\_\_\_

Investigator's signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix G

### Interview Guide

I'm here to try and learn more about some of the organizational changes that are happening in your workplace. Organizational changes in health care are occurring rapidly and continuously but there's not a lot of research about how nurses are experiencing these changes in their workplaces. I believe that nurses have unique experiences in health care and that nurses have valuable insights into organizational changes happening in their workplaces. I would love for you to share with me some of your recent experiences.

### Interview questions

1. Could you tell me about some of the organizational changes happening within your workplace?
2. Could you tell me what is it like to be a nurse experiencing the kinds of changes you speak of?
3. How have these changes made you feel?
4. What sorts of things have positively impacted your experiences? What sorts of things have perhaps negatively impacted your experiences?
5. Could you tell me about your involvement in the change processes?
6. Could you tell me a little about how these changes have impacted the way that you provide patient care?
7. Is there anything else you would like to add or feel I've missed?