Surgical Nurses' Experience of Hallway Healthcare

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Preface

Statement of Contributions

This thesis represents original work by Zoe Ruddy, completed in partial fulfillment of the requirements for the Master of Science in Nursing at the University of Ottawa. Zoe Ruddy, the student researcher was responsible for the conceptualization of the study, informed by her experience as a surgical nurse and developed in consultation with the thesis supervisor. She conducted the literature review, led participant recruitment, collected the data, and completed the preliminary data analysis in consultation with the thesis supervisor. She drafted and revised all sections of the thesis (and manuscript) and was responsible for integrating the findings and developing the discussion.

Dr Christine J. McPherson, the thesis supervisor, provided substantial intellectual and methodological guidance throughout all phases of the research. This included contributing to study conceptualization, refining the research questions, methodology and methods, and engaging in data analysis. The supervisor was substantively involved in the writing, critical review, and revision of the thesis and manuscript (chapter 4) and provided ongoing mentorship throughout the research process.

Drs. Brandi Vanderspank-Wright and Kimberly McMillan, the thesis committee members provided advisory oversight throughout the research process. They reviewed and approved the thesis proposal, reviewed the preliminary thematic structure during data analysis, and provided feedback and suggestions on the thesis and manuscript (chapter 4) prior to approving for submission.

Abstract

Background: Hallway healthcare refers to the practice of providing patient care in hospital hallways. Although traditionally associated with overcrowded emergency departments, this practice has increasingly extended into inpatient units as a strategy to alleviate chronic overcrowding and improve bed flow. This study explores nurses lived experiences of providing hallway healthcare in surgical inpatient settings. **Methods:** A qualitative study, guided by interpretive description, was used to explore the experiences of nurses working in surgical inpatient settings in Ontario, Canada. Purposeful sampling was used to recruit nine nurses with direct experience providing hallway healthcare. Data were collected through individual semi-structured interviews and analyzed thematically to identify key patterns relevant to the focus of the inquiry. **Results:** Three main themes were identified: *Part of the Job; Responsible Without Power; Constrained in Care and Voice*; and *Relational Disruption*. Rather than serving as a temporary strategy to facilitate bed flow, hallway healthcare had become routine. Driven by top-down organizational decisions, participants' practice was constrained within spaces perceived as unsafe. The presence of patients in hallways, alongside overextended staff, eroded trust, strained relationships, and ultimately compromised the quality of patient care participants felt they were able to provide. **Conclusion:** The findings add to the growing literature on the adverse impact of hallway healthcare and underscore the need for healthcare systems and organizations to move beyond it by investing in capacity, workforce, and environments that enable safe, ethical, and dignified practice.

Keywords: hallway healthcare, hallway medicine, hospital overcrowding, patient safety, nurse-patient relations, nurse well-being

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Chapter 1 Introduction

1.1 Research problem

In Canada and around the world, healthcare systems are experiencing pressure from an influx of patients requiring admission to hospitals (Feldman, 2020). Patients arriving at the emergency department often encounter lengthy wait times and overcrowded conditions (Feldman, 2020; Kaplan & McGinnis, 2015). It is common for hospitals to place patients in hallways to manage bed shortages and improve patient flow (Lopez et al., 2022). "Hallway healthcare," also referred to as "hallway medicine," describes the provision of care to patients placed in hospital hallways and falls under the umbrella term of "alternate care areas" (De Leon et al., 2020; Lee et al., 2020). These are nontraditional areas within the hospital used for patient care and include conference rooms, laboratories, endoscopy suites, and hallways, where patients are admitted when no designated bed space is available (Lee et al., 2018). While hallway healthcare may temporarily increase hospital capacity, it poses significant challenges that negatively affect patients, their families, and healthcare staff.

Hallway environments often lack essential medical resources, such as oxygen and suction equipment, creating safety concerns and potentially compromising patient care (Amara, 2024; Chang et al., 2016; Richards et al., 2011). These settings can also reduce patients' and families' access to staff, decrease comfort, and compromise privacy and dignity (Richardson et al., 2020; Stiffler et al., 2014; Villalona et al., 2020). Furthermore, the lack of privacy can discourage patients from discussing sensitive issues openly with their healthcare providers, potentially violating confidentiality laws and weakening trust in the patient–provider relationship (Amara, 2024; Chang et al., 2016; Richards et al., 2011; Pentecost et al., 2020).

Hallway healthcare affects frontline care providers by increasing workload, creating time management difficulties, and contributing to higher stress levels (Canadian Nurses Association

[CNA], 2024; Lopez et al., 2022). Nurses, as the largest group of healthcare professionals and the primary point of contact for patients and families, are particularly affected. These conditions can compromise their ability to provide safe, quality care and establish therapeutic relationships, leading to decreased job satisfaction, fatigue, and potential burnout (Canadian Federation of Nurses Unions [CFNU], 2009; Ontario Nurses Association [ONA], 2007).

Although hallway healthcare occurs across various inpatient settings, there remains limited understanding of nurses' experiences outside the emergency department context. This gap in understanding highlights the need for further research exploring nurses' experiences in other clinical areas to gain deeper insight into their specific contexts and better support them in practice. Drawing from my experience as a surgical nurse on an orthopedic surgical unit, this study focuses on understanding the experiences of surgical nurses who provide hallway healthcare. I will begin by sharing a narrative reflection on my own clinical experience to connect it with the broader issue of hallway healthcare and to highlight the challenges. I will then provide background context for my study and outline the aims of the research.

1.2 Reflecting on my experience of hallway healthcare

I began my nursing career during an unprecedented time in history, at the height of the COVID-19 pandemic, when uncertainties about the virus and overwhelming demand for healthcare were at their peak. While I had encountered patients in the hallway in the emergency department and understood the pressures within it, I was not familiar with the use of alternate care areas outside of the emergency department. However, in my role as a surgical nurse in orthopedic surgery, I frequently encounter hallway healthcare. In any given month, I encounter hallway healthcare approximately 20 to 30 times. This experience spurred my interest in researching the phenomenon from the perspectives of nurses outside of the emergency

department and within the surgical inpatient setting.

My practice as a surgical nurse in orthopedic surgery primarily focuses on providing preoperative and postoperative care. Most of the patients I care for are older adults admitted for hip and knee replacements, often following fractures from falls or cancer. This patient population is vulnerable to health risks because of advanced age and the high prevalence of comorbidities. These factors add another layer of acuity to the care of these patients and to the complexity of surgical nursing. Working on these units presents significant challenges because of busy schedules and high patient loads. In my current role, the nurse-to-patient ratio is 1:4 during the day and 1:6 at night. When patients are allocated to the hallway, the ratio can become 1:5 during the day and 1:7 at night. Should staff shortages occur, the ratios can reach 1:6 during the day and 1:8 at night. In my experience, higher patient-to-nurse ratios not only diminish the quality of care but also increase the stress and anxiety nurses feel. I will now briefly describe the physical space of hallway healthcare where I work.

The unit where I work consistently places patients admitted to the hallway next to the only hallway bathroom, which is close to the nursing station and directly across from the medication and clean supply room. As the hallway is a passageway, it is busy both day and night. Despite the reduction in lighting at night, the hallway remains partially lit for safety reasons. Perhaps not surprisingly, patients find it difficult to sleep or rest there. During the day, the hallway bustles with daily activities such as physical therapy and patient mobilization, both of which play a crucial role in the postoperative care of orthopedic patients. All of this occurs near the patient's space in the hallway, which is highly disruptive and infringes on privacy. Enclosing the bed against the wall with room dividers provides some sense of privacy, but it restricts space around the bed for standing, sitting, or visiting with family and friends.

I will reflect on my experience by illustrating issues with hallway healthcare through a narrative. This story revolves around Mrs. G, a young married mother who suffered a broken humerus while ice skating with her children. After spending a long, arduous night on a stretcher in the emergency department, the orthopedic unit admitted Mrs. G. Despite anticipating a bed in one of the unit's rooms, we admitted her to one in the hallway, where she would spend two more nights before her surgery. During this time, she struggled to sleep because of the constant activity in the hallway, while the lack of privacy hindered her ability to communicate with staff. During my night shifts, I cared for her and six other patients, limiting the time available to interact with her or build a relationship. This left me feeling as though I had neglected her. Despite my desire to provide her with better care, I felt morally distressed because I could not offer the standard of care I believed I could provide.

I was confident that Mrs. G would not return to the hallway of the unit following her surgery, as it lacked the equipment and space for immediate postoperative care such as a vital signs machine, oxygen, suction, and even a code blue button if needed. When Mrs. G left for the operating room (OR), I reassured her that she would not be coming back to the hallway after surgery. Later that night, I learned that Mrs. G's surgery had proceeded smoothly and that, following her recuperation in the post-anesthesia care unit (PACU), she would return to the unit and the hallway. I was frustrated and outraged after hearing this. Although it was not my decision to place Mrs. G back in the hallway, I felt responsible for the situation, especially after reassuring her that she would not be there again. While advocating for my patient, I contacted the on-site coordinator to express my concerns but was ultimately unable to influence the decision. Even though I believed the situation to be unsafe, I felt powerless because I could not change the outcome. As nurses, we have limited control over these decisions, despite our responsibility for

patient safety and care. The decision to place Mrs. G in the hallway was based on her age and health. Her post-surgery risk was comparatively lower than that of other patients in our care. However, many patients I care for are older and have other health issues; placing them in the hallway increases their risk of confusion and falls because of the unfamiliar surroundings, noise, and busyness of the unit hallways.

Mrs. G did not return from PACU and discharged herself home instead. Her husband came to collect her belongings. He was upset and explained that receiving care in the hallway made Mrs. G feel devalued and disrespected by the hospital. I apologized and empathized with him. Although Mr. G understood and made it clear that he knew it was not my fault, he was still upset with the outcome. Mrs. G's decision to discharge herself early is a common occurrence among patients I have encountered in hallways. Her experience exemplifies how hallway healthcare runs counter to patient-centred care and the inherent values we, as nurses, seek to preserve.

1.3 Broader context contributing to hallway healthcare

My experience with hallway healthcare illustrates how using hallways as one "solution" to systemic bed shortages negatively affects both patient care and nursing practice. To understand why hallway healthcare is occurring, it is important to examine the broader contextual factors contributing to the issue. A major factor underlying hallway healthcare is the growing demand on health services, along with the finite resources allocated to meet those demands. This strain on inpatient healthcare is the result of multiple factors, including advances in medicine and treatments, an aging population, and inadequate primary healthcare and community resources (HomeCare Ontario, 2024; Ontario Hospital Association, 2019; Ontario Health, 2019). A shortage of primary care physicians adds to the problem and pressure on

hospitals, leaving many Canadians without a family doctor and forcing them to rely on the emergency department for non-urgent medical needs (Canadian Institute for Health Information [CIHI], 2024). As a result, hospitalizations in Canada are increasing and are expected to continue rising. In 2023–2024, there were 3.05 million hospitalizations, up from 2.96 million in the previous year (CIHI, 2025).

The aging population significantly contributes to this demand, as older adults are more likely to have chronic conditions that require hospital admission, as well as longer hospital stays (CIHI, 2025). Of the top five reasons for hospital stays in Canada, three are age-related conditions: chronic obstructive pulmonary disease (COPD) and bronchitis, heart failure, and myocardial infarction (CIHI, 2025; Public Health Agency of Canada, 2020). As the projected proportion of older adults aged 65 years and older in Canada increases to one-fourth of the overall population by 2040, the demand for hospital and community services will continue to rise (Public Health Agency of Canada, 2020).

Within the surgical context, this demand is clear. Osteoarthritis, for example, is the most common cause of inpatient surgery in older adults, leading to a high demand for knee and hip replacements (CIHI, 2025). The recommended wait time for knee or hip replacement surgery is six months; however, in 2024, only 68% of hip replacements and 61% of knee replacements were completed within this time (CIHI, 2025). This represents a decline from five years earlier, when 75% of hip replacements and 70% of knee replacements met the six-month benchmark (CIHI, 2025). These delays contribute to longer hospital stays and create greater strain on surgical units.

Hospital overcrowding is further compounded by the growing number of patients identified as requiring an alternate level of care (ALC), as well as inadequate primary and

community care resources. Patients identified as ALC no longer require acute hospital care and remain in hospital while waiting for placement in long-term care, retirement homes, or home care services (CIHI, 2016). However, insufficient community services, staffing shortages, and underfunding create significant capacity issues, which have led to growing waitlists for placements and home care (CareFor, 2024; City of Ottawa, 2025; ONA, 2024). In Ontario, for example, older adults wait an average of 125 days for long-term care admission, with some waiting up to two and a half years (Ontario Long-Term Care Home Association [OLTCA], 2023). For home care services, the average wait time in Canada is three days (CIHI, 2025). This growing demand underscores the multiple factors driving hospital overcrowding that contribute to hallway healthcare as a "solution" and reinforces the urgent need for investment in healthcare infrastructure and resources across primary, tertiary, and community care so that the system can meet current and future challenges (Cheese, 2024; Health Quality Ontario, 2023; Ontario Long-Term Care Home Association, 2025).

1.4 Background to hallway healthcare

For many in the public, the COVID-19 pandemic revealed longstanding issues related to overcapacity and bed shortages within Canada's healthcare system, as well as the growing need to use alternative areas for patient care (Rail, 2024). However, hallway healthcare is a longstanding issue that existed long before the COVID-19 pandemic. Historically, the use of nontraditional care areas was identified as early as the 1950s (Sadri & Fraser, 2022). Although the exact origins of hallway healthcare are unclear, a series of articles published in *Maclean's* magazine as early as 1952 highlighted problems within the Canadian healthcare system, including hallway healthcare (Sadri & Fraser, 2022). In the 1980s, overcrowding in emergency departments was a growing concern, with demand for services exceeding available resources

(MacIsaac & Peter, 2025). Placing patients in emergency department hallways was considered a solution to relieve temporary periods of overcrowding during peak demand periods such as the winter flu season (Richards, Van der Linden, & Derlet, 2014). However, ongoing system strain has created chronic overcrowding and persistent bed shortages, extending the use of hallway healthcare beyond the emergency department to other inpatient hospital units.

To ease overcapacity, hospitals have implemented various protocols and strategies to manage patient flow and bed shortages. These "surge plans" are short-term measures aimed at addressing immediate needs, such as moving patients from overcrowded emergency departments to alternative care areas to free up space for new admissions (Kreindler et al., 2020). While surge plans address immediate capacity pressures, hospitals often rely on these short-term measures rather than developing sustainable, long-term solutions. Indeed, contingency plans that include hallway healthcare as a response to overcapacity and insufficient inpatient beds reinforce the notion of hallway healthcare as a viable option and perpetuate it as the norm (Feldman, 2019; Lee et al., 2018; Alishahi Tabriz et al., 2019).

Public attention to hallway healthcare has increased through mainstream media, with many reports highlighting the harrowing experiences of patients receiving care in hospital hallways (Buffam, 2024; Butler, 2022; Cheese, 2024; Favaro, 2023; Skulski, 2024). For example, a case reported by the Canadian Broadcasting Corporation (CBC) News described the plight of an older man who waited four days in the hallway of an emergency department with a fractured femur before being transferred to an inpatient bed and receiving surgery (Butler, 2022). His experience, like Mrs. G's in my narrative reflection, exemplifies the vulnerability and sense of powerlessness experienced by patients in these situations.

Similar accounts have been reported across Canadian media outlets such as CBC and

CTV, as well as in the research literature, highlighting the realities of overcrowding and the growing reliance on alternative spaces such as hallways for patient care (Beswitherick, 2022; Buffam, 2024; Cheese, 2024; Favaro, 2023; Lee, 2024; Skulski, 2024). In 2023, CBC News reported that hallway healthcare was becoming increasingly common in Ontario hospitals because of overcrowding and staffing shortages (Favaro, 2023). The research literature, media outlets, healthcare lobby groups, and non-profits continue to emphasize hallway healthcare as a symptom of deeper systemic issues within Canada's healthcare system, calling attention to the need for action (Cheese, 2024; Lee, 2024; OHA, 2019).

1.5 The hallway as a designated patient care area

As noted, using hallways as patient care areas is an increasingly widespread practice; however, it raises significant concerns for patient care and safety, as hallways are environments not conducive to care. Hallway spaces are not designed or equipped to serve as care areas, as they lack critical infrastructure such as privacy partitions, accessible medical equipment, and adequate lighting (McNaughton et al., 2011). For those providing care, delivering care in hallways is physically taxing because of space constraints (Ontario Health, 2019). Supplies needed for patient care may not be readily available, and the lack of vital equipment such as in-wall oxygen and suction can have serious implications during emergencies or patient deterioration (Richards & Derlet, 2022). The lack of a call bell system further compromises patient safety by limiting patients' ability to contact staff when assistance is required. Access to other patients requiring urgent interventions may also be impeded, as hallway beds obstruct the movement of essential mobile equipment such as portable x-ray machines and electrocardiogram units. Furthermore, hallway beds can hinder the evacuation of patients during emergencies such as fires.

Hallways are thoroughfares and, as such, lack privacy, which compromises communication, patient dignity, and the therapeutic relationship (Richards & Derlet, 2022). Increased exposure to staff and visitors walking through the hallways heightens patients' discomfort and leaves them feeling unsafe (Richards & Derlet, 2022). Consequently, some patients may decline physical assessments and examinations because of concerns about being observed (McNaughton et al., 2011). The hallway environment is also inappropriate for discussing sensitive health information, making patients less forthcoming or comfortable sharing personal details or asking questions of healthcare providers (Ontario Health, 2019). This situation limits patient–healthcare provider engagement, making it difficult for staff to communicate essential medical information, even when such discussions are critical to patient assessment and the delivery of patient-centred care (Richards & Derlet, 2022). The lack of privacy afforded to patients and their families, and its impact on their sense of dignity, diminishes communication and trust in the nurse–patient therapeutic relationship (Pentecost et al., 2020).

To create a semblance of privacy, portable screens or plastic room dividers are often used to shield patients from view and provide discretion during sensitive conversations, examinations, and procedures. However, they do little to block noise or prevent interruptions, leaving patients feeling exposed and vulnerable (Lee, 2024). Patients placed in hallways near the nursing station can overhear conversations about other patients, compromising confidentiality and undermining trust (Chang et al., 2016; Gill, 2023; Villalona et al., 2020). These points highlight the unsuitability of hospital hallways for patient care, as they pose a risk to patient safety and compromise patients' privacy and dignity, which are central to patient-centred care.

1.6 The surgical inpatient care setting and surgical nursing

Researchers have primarily examined hallway healthcare in the emergency department (Feldman, 2020; Lee et al., 2018; Pines et al., 2007; Villalona et al., 2020). Yet, hallway healthcare occurs across a range of inpatient units, including medicine, surgery, and oncology. Only highly specialized areas such as labour and delivery or intensive and critical care units have strict nurse-to-patient ratios that prevent hallway healthcare. Although the fundamentals of nursing care are similar across settings, the specifics of care plans and patient goals differ based on the clinical context and individual patient needs and preferences. My experience with hallway healthcare as a surgical nurse, as described in my narrative reflection, prompted my interest in exploring hallway healthcare from the perspective of surgical nurses. To provide context for the study, I will describe the surgical setting and surgical nursing.

Surgical units often operate at full capacity because of the high demand for both elective and emergency surgeries. This demand is intensified by limited operating room availability and a shortage of specialized staff (Kaplan & McGinnis, 2015). Surgical inpatient units are typically organized by specialties such as orthopedics, gynecology, general surgery, thoracic surgery, and nephrology. For example, on orthopedic surgical units, joint replacements are common elective surgeries, while fractures typically require emergency surgery. The patient population in surgical units is diverse and includes individuals undergoing both elective and emergency surgical procedures. Many patients requiring surgical care, particularly older adults, have complex needs and multiple comorbidities that increase the risk of complications (Partridge et al., 2018). The urgency and unpredictability of emergency surgeries add further complexity to care, requiring rapid assessment, clinical decision-making, and timely intervention to ensure patient safety and promote recovery. Surgical nurses play a critical role in addressing the complex needs of patient

care preoperatively and postoperatively as part of the healthcare team (Nazon et al., 2022). Surgical nurses represent a significant group within the broader category of medical-surgical nurses and make up the largest single group, accounting for 18% of all employed registered nurses in Canada (Canadian Association of Medical and Surgical Nurses, 2017). They are experts in their surgical specialty and are trained to manage complications and potential implications specific to their surgical unit. Preoperative care emphasizes stabilizing existing conditions and preparing patients physically and psychologically for surgery, while postoperative care centers on promoting recovery, preventing complications, and helping patients return to their functional baseline (Yoder, 2018). During the immediate postoperative period, patients are at heightened risk for adverse reactions, such as pain and respiratory distress, following the physiological stress of surgery and anesthesia (Nazon et al., 2022). For this reason, in addition to an in-depth understanding of preoperative and postoperative care, surgical nurses possess a broad range of knowledge related to health and illness, strong critical thinking and clinical decision-making skills, and the ability to adapt to rapidly evolving situations within a highly demanding environment (Pepe & Altmiller, 2024).

Adding patients to hallways in inpatient surgical units intensifies an already challenging and demanding situation. Even though hallway healthcare is well recognized in emergency departments and there are similarities between the experiences of emergency department nurses and surgical nurses, the inpatient surgical context presents distinct challenges unique to its setting.

1.7 Research aims and question

The aim of this study was to gain a deeper understanding of hallway healthcare from the perspectives of surgical nurses. The research question is: *What are the experiences of surgical*

nurses caring for patients in hallways? By exploring hallway healthcare, this study seeks to provide a voice for Canadian surgical nurses to express their experiences and raise awareness of their concerns. Understanding the challenges nurses face with hallway healthcare within their specific contexts provides valuable insights and helps inform policies and practices to better support nurses. This is significant in the current climate of nursing shortages, as hallway healthcare contributes to increased patient load, unhealthy work environments, and moral distress (Amara, 2024; Chang et al., 2016; Richards et al., 2011), factors commonly associated with nurses' decisions to leave the profession (CFNU, 2012; CFNU, 2022; Lyu et al., 2024).

1.8 Organization of the thesis

This thesis is organized into five chapters. Chapter Two builds on the discussion presented in Chapter One and provides a review of the literature, outlining current evidence and knowledge gaps related to hallway healthcare and its impact on nurses, patients, and their families. This chapter also examines health policy related to hallway healthcare, including institutional procedures and overcapacity protocols that permit patient placement in hallways. The chapter concludes with a description of the Registered Nurses' Association of Ontario's (RNAO) Model of a Healthy Work Environment (HWE) (2007), which provides the conceptual framework for the study. The HWE Model (RNAO, 2007) conceptualizes the intersections among system, organizational, and individual factors that influence nurses' work environments. Chapter Three outlines the qualitative methodology, including the research design, participant recruitment, sample and sampling strategy, data collection, analytic approach, rigor, and research ethics. In alignment with Thorne's (2016) interpretive description methodology, theoretical scaffolding is discussed with reference to the HWE Model (RNAO, 2007), relevant literature, and my positionality as a nurse pursuing graduate education, including assumptions related to the

phenomenon of interest. Chapter Four presents the study findings in the form of a manuscript prepared in accordance with the submission guidelines of a peer-reviewed nursing journal. This chapter is intended for publication and contributes to the growing body of knowledge on hallway healthcare and nursing work environments. Chapter Five discusses the findings in relation to existing literature and the HWE Model (RNAO, 2007). The implications of the research are examined, with particular attention to advanced practice nurses (APNs). As an RN enrolled in a graduate nursing program, examining the APN role is essential to understanding how graduate-level competencies such as evidence-informed practice, leadership, and consultation can be applied to support nurses in their practice and facilitate organizational and system-level change toward healthier, more sustainable work environments. The chapter discusses future directions for research, study limitations, and concludes with a summary.

Overall, this thesis provides an in-depth examination of hallway healthcare by integrating literature, theory, and the lived experiences of surgical nurses, while critically considering the implications for nursing practice and work environments within the Canadian healthcare context.

Chapter 2 Literature Review

2.1 Introduction

This chapter synthesizes and summarizes the literature examining hallway healthcare. Building on the discussion of systemic factors contributing to hallway healthcare in Chapter One, the first section examines overcapacity and surge protocols that inform the management of situations in which hospitals operate beyond their capacity. Hallway healthcare is one strategy incorporated within these protocols. The discussion then turns to the impact of hallway healthcare on patients and families, highlighting the implications for privacy, comfort, and safety. It then shifts to nurses' perspectives to provide background for this study, focusing on the impact of hallway healthcare on nurses' work environments, professional satisfaction, and overall well-being. This section concludes with an overview of the Registered Nurses' Association of Ontario's (RNAO) Model of a Healthy Work Environment (HWE) (2007), which serves as the conceptual framework guiding this research.

2.2 Review of the literature

A broad review of the literature on hallway healthcare was conducted to examine its scope across disciplines, including nursing, medicine, management, policy, and hospital design (Ahalt et al., 2018; Ergin et al., 2011). As the aim of the inquiry was to gain a deeper understanding of hallway healthcare from the perspectives of surgical nurses, the literature review focused on studies examining relevant policies, as well as the perspectives of patients, families, and nurses (refer to Appendix A for details on the search strategy). The identified literature spanned several countries, including Canada, the United States, Sweden, and England, underscoring the breadth and international scope of the issue (Bostock, 2025; Foss & Krogstad, 2000; McNaughton et al., 2012; Rixe et al., 2018). Although hallway healthcare occurs in various hospital settings, the existing literature is largely situated in the emergency department (Lee et al., 2018; McNaughton et al., 2012; Richards, 2022). Studies specifically exploring

patient and nurse experiences are limited and are primarily quantitative, focusing on outcomes such as safety, communication, and satisfaction (Chang et al., 2016; Richards & Derlet, 2022; Lee et al., 2018; Lee et al., 2020; Pines et al., 2007; Richardson et al., 2020; Stifler & Wilber, 2015; Viccellio et al., 2008). Based on the literature review, the following themes were identified and will be discussed to provide a basis for the proposed research: *health policy, patient and family perspectives*, and *nurse perspectives*.

2.3 Health policy and hallway healthcare

Hallway healthcare, as discussed in Chapter One, is a product of systemic issues related to overcapacity, underfunding, and limited resources (CFNU, 2022; OHA, 2019; Ontario Health Coalition, 2025). The accepted safe occupancy rate within hospitals is 85% (CFNU, 2012). However, many hospitals in Canada are operating beyond 100% capacity and have been doing so for prolonged periods, ranging from months to years (Varner, 2023). This means that all rooms are full and there is no space for new admissions until patients are discharged or transferred. How hospitals respond to overcapacity is highly variable, highlighting that hallway healthcare is not only an operational issue but also one shaped by policy.

Health policy, as it relates to hallway healthcare, refers to the policies and procedures that encompass institutional processes and overcapacity protocols that authorize patient placement in hallways. Many institutions do not have well-defined policies or procedures in place, while others have developed overcapacity policies that are used on an ad hoc basis. A distinct group of interventions, commonly referred to as overcapacity management, has been developed to address these situations (Kreindler et al., 2020). While each hospital has its own overcapacity or surge protocol, they share a common goal: to move patients to other locations within the hospital to free up space for new admissions (Kreindler et al., 2020).

Activation of overcapacity protocols varies by organization but is typically based on one of two triggers: the number of ambulances waiting to offload patients or the National Emergency Department Overcrowding Study (NEDOCS) scoring system (Halton Healthcare, 2023; Michigan Department of Health, 2018; Nova Scotia Health, 2023). The NEDOCS score is calculated using several variables, including the total number of emergency department patients and beds, the number of inpatient beds, the most recent waiting time, the longest current boarding time, and the number of emergency department patients on a ventilator (Ahalt et al., 2018). Scores above 115 indicate severe overcrowding requiring a response (Michigan Department of Health, 2018; Nova Scotia Health, 2023). The NEDOCS scale, frequently cited in overcapacity protocols (Ergin et al., 2011), is a common method for assessing overcrowding. Some hospital protocols instead rely on ambulance offload delays, with three or more vehicles waiting over an hour serving as the threshold for activation (Halton Healthcare, 2023). Across institutions, overcapacity protocols share the goal of ensuring timely access to inpatient beds and maintaining appropriate ambulance offload and emergency department wait times. In Ontario, the province expects admitted patients to reach an inpatient bed within eight hours of being seen in the emergency department (Ontario Health, 2019). However, the normalization of these protocols has enabled and justified the ongoing use of hallway healthcare (CFNU, 2009; OHA, 2019).

At the organizational level, the response is driven by the need to manage an overwhelming volume of patients in the emergency department alongside insufficient inpatient bed capacity (Alberta Health Services, 2010; Halton Healthcare, 2023; Horizon Health Network: Saint John Regional Hospital, 2013; Nova Scotia Health, 2023; Thunder Bay Regional Health Sciences Centre, 2014). In Ontario, the target wait time for patients to transfer from the

emergency department to an inpatient bed is within eight hours of being seen (Ontario Health, 2019). This target is incorporated into some overcapacity protocols to support adherence. The primary intervention used within these protocols involves moving patients to the most appropriate available space within the hospital (ONA, 2007). When enacted, overcapacity protocols may involve the use of hallways, closets, quiet rooms, offices, off-service beds, and co-hosting arrangements (ONA, 2007). While some institutions have strict criteria for patient placement in nontraditional care spaces, others rely on leadership and bed flow decisions made on a case-by-case basis (Betsy Lehman Centre for Patient Safety, 2019; Halton Healthcare, 2023). In situations where a patient is deemed unsuitable for hallway placement (e.g., medically unstable), a clinically stable inpatient or one ready for discharge may be temporarily relocated to an alternative care space (Betsy Lehman Centre for Patient Safety, 2019).

External policies, including government regulations, safety standards, and professional guidelines, significantly influence how institutions implement overcapacity protocols (Alishahi Tabriz et al., 2019). These policies establish the legal and operational framework within which hospitals must function. Regulations related to patient safety, billing practices, privacy laws, and quality standards directly shape hospital procedures and workflows. In Ontario, the Ministry of Health's Capital Planning Framework provides guidance to hospital leaders when planning infrastructure projects, with the goal of delivering effective, accessible, and efficient health services while maintaining the needs of patients and staff (Ontario Health, 2019). Hospitals must meet key principles such as safety, security, and operational efficiency (e.g., lighting and noise control) to receive approval. At the same time, regulations such as fire codes and facility design standards may restrict the use of hallways or alternate care areas for patient placement due to safety concerns (Alishahi Tabriz et al., 2019).

For the nursing profession, guidelines established by regulatory bodies and professional organizations also influence how overcapacity protocols operate (Ontario Ministry of Health and Long-Term Care, 2009; RNAO, 2017). Transferring patients to hallway spaces may compromise safe nurse-to-patient ratios; however, keeping patients in an overcrowded emergency department also presents significant safety risks (Alishahi Tabriz et al., 2019).

Recognizing the negative effects of hallway healthcare, as outlined in Chapter One, various strategies have been proposed to mitigate its impact (CFNU, 2022; HomeCare Ontario, 2024; OHA, 2019; RNAO, 2024). These include improving hospital capacity planning, enhancing resource allocation, and strengthening staff retention. While such strategies are important, the predominant focus on mitigating the symptoms of hallway healthcare does not address its underlying systemic causes.

2.4 Patient and family perspectives of hallway healthcare

Policies developed to address hospital overcapacity often prioritize efficiency and patient flow while overlooking the human impact of these conditions. In doing so, they risk reducing complex care experiences to logistical challenges, neglecting how these environments affect both patients and families. For those placed in hallways, care becomes more visible yet less personal, exposing vulnerabilities in dignity, communication, and safety (Pines et al., 2008; Richards et al., 2014; Villalona et al., 2020; Walsh & Bhakta, 2008). Patients and their families entering the hospital for treatment expect a certain level of care, having a designated bed is an integral part of this expectation. However, the reality is that many patients will spend a portion of their hospital stay in alternate care areas, such as hallways (Ontario Health, 2019). While there is media attention drawn to some prominent cases as, mentioned in Chapter One, a deeper understanding from the perspectives of patients and families provides valuable insight into the ways in which

patient care is compromised when it is provided in the hallways of hospitals. The following section examines this literature, exploring how hallway environments shape perceptions of care quality, emotional wellbeing, and overall satisfaction.

When patients are informed that they will be cared for in a hallway there is often disbelief and outrage (Favaro, 2023). As described in chapter one, hallways are not designed for patient care and lack fundamental resources and the supportive environment required to provide safe, dignified, and quality care. Limited access to necessary medical equipment and supplies can further delay timely interventions, while the physical layout of hallways is not designed to accommodate urgent care needs or safely manage medical emergencies (Richards & Derlet, 2022; van Loveren et al., 2021). Additionally, the lack of privacy exposes patients to continuous observation by staff, visitors, and other patients, which can be distressing and intrusive (Pulliam et al., 2013). The persistent noise, lighting, and overall stimulation in hallways also places a significant toll on patients' mental health and hinders their ability to rest and recover effectively (Buffam, 2024).

Research indicates that patients cared for in hallways experience delays in diagnostic testing, treatment initiation, and disposition planning, which can all prolong recovery and extend hospital stays. The suboptimal hallway environment also contributes to delays in medication administration and laboratory tests and increases the risk of adverse events such as unrecognized patient deterioration (Derlet et al., 2014; Richards & Derlet, 2022). Overcrowding exacerbates these risks as the number of patients that nurses must care for increases, often beyond safe staffing levels, impacting the quality of patient care (Derlet et al., 2014).

Overstimulation from constant lighting and noise in hospital hallways is highly disruptive to rest and sleep, which can contribute to prolonged hospital stays and additional medical

complications (Richards & Derlet, 2022). Complications experienced by hallway patients include unrecognizes respiratory arrest, delay in time-sensitive procedures and laboratory testing, unrelieved pain, delay in important medications, overall increased length of stay, and exposure to traumatic psychological events (Richards et al., 2014). These environmental stressors were also reported to not only impede recovery but also heighten feelings of frustration and helplessness among patients. One compelling account from a man in Vancouver, reported by *Global News*, described spending nine days admitted in a hospital hallway. He recounted the constant movement of people, relentless noise, and lights that remained on 24 hours a day, expressing that he "just wanted out" the entire time (Judd & Stanton, 2024).

Effective clinician-patient communication is an essential part of care and is associated with decreased patient anxiety and increased patient satisfaction (Chang et al., 2016). Patients in hallways report rushed impersonal and poor communication with their providers. These authors reported that many lack access to call bells to request assistance, which can lead to patients to feel neglected, overlooked, and invisible (Foss & Krogstad, 2000; Skulski, 2024). In a study examining communication and satisfaction among hallway patients in the emergency department, Villalona, et al. (2012) found that these patients reported negative experiences. Many expressed feeling forgotten during their evaluations, with dissatisfaction linked to long wait times, limited communication, and minimal time with nurses. Additionally, patients felt that their concerns were not taken seriously or adequately addressed, leaving many questions about their condition and treatment unanswered (Villalona et al., 2020). As a result, overall patient satisfaction in this study was significantly lower among those located in hallway settings.

The finding that satisfaction with care is eroded when patients are placed in hallways is not surprising (Chang et al., 2016; Pines et al., 2007; Richardson et al., 2020; Stiffler & Wilber,

2014; Villalona et al., 2020). Within the emergency department one study found patients expressed less satisfaction with the medical care, reported lower ratings of the emergency department, and were less likely to recommend the emergency department to others compared to patients not placed in hallways (Richardson et al., 2020). Of note, family members of patients placed into hallways also reported lower satisfaction with care (Richardson et al., 2020). Since patient satisfaction directly influences the quality of patient–clinician relationships and patient adherence to treatment recommendations (Stiffler & Wilber, 2014), these findings have broader implications for quality patient care and outcomes.

Reflecting a level of pragmatism with hallway healthcare are studies examining the experiences of patients placed in hallways across hospital settings (Richards et al., 2011; Viccellio et al., 2013; Walsh, Cortez, & Bhakta, 2008). Comparisons between emergency department hallways and in-patient hallways consistently show that inpatient settings are preferred (Richards et al., 2011; Viccellio et al., 2013; Walsh, Cortez, & Bhakta, 2008). The authors attribute this preference to reduced noise levels, greater privacy and confidentiality, improved comfort and rest, better access to nursing staff, and fewer surrounding hallway patients, in contrast to the overcrowded and high-intensity atmosphere of the emergency department (Richards et al., 2011; Viccellio et al., 2013). A minority of patients preferred the emergency room hallways because of easier access to physicians despite issues with privacy and noise (Walsh, Cortez, & Bhakta, 2006).

In summary, the literature consistently highlights a decrease in quality care when patients are placed in the hallway. The primary concerns for patients and families are patient safety, privacy, and dignity. Fragmented communication and therapeutic relationships with providers are also an issue for these patients. In nursing, effective communication and strong therapeutic

relationships are vital to quality care. When these relationships breakdown or mistrust develops, it becomes difficult for nurses to provide holistic, patient-centred care. This will be discussed in more depth the next section along with literature that has examined nurses' perspectives and outcomes associated with providing hallway healthcare.

2.5 Nurses' perspectives of hallway healthcare

This section begins with a discussion of the literature, both within and outside Canada, that has examined hallway healthcare from nurses' perspectives. These studies provide important insight into how nurses navigate the challenges associated with providing care in hallways. The discussion then links these findings to professional standards and core nursing principles, including the therapeutic nurse–patient relationship and the provision of patient-centred care. Finally, the review expands to consider broader systemic critiques and recommendations aimed at addressing the root causes of hallway healthcare and promoting safe, sustainable nursing practice.

2.5.1 Individual and relational impacts

Research examining hallway healthcare from nurses' perspectives has largely focused on the emergency department, where the effects of overcrowding are most visible. Studies show that nurses struggle to deliver safe, ethical, and person-centred care in these environments because of limited space, lack of privacy, and continuous workflow interruptions (Chang et al., 2016; Villalona et al., 2020).

The therapeutic nurse–patient relationship is grounded in trust. When patients are placed in hallways, their confidence in the healthcare system may diminish, negatively affecting the development and maintenance of therapeutic relationships (Chang et al., 2016; CFNU, 2009; Pines et al., 2007; Richardson et al., 2020; Villalona et al., 2020). As a result, nurses may

experience dissatisfaction with the care they provide and their ability to meaningfully connect with patients. Distrust and frustration expressed by patients in hallway settings can also contribute to increased incidents of harassment and violence toward nurses (CFNU, 2022; ONA, 2021; RNAO, 2024).

A survey study by Pulliam et al. (2013) explored the attitudes of American emergency department and adult inpatient (ward) nurses toward hallway healthcare. Participants were asked to consider hypothetical patient scenarios and indicate appropriate boarding locations, as well as their personal preferences if they were patients. Findings revealed differences based on clinical experience. Nurses with emergency department experience were more likely to prefer ward hallways over emergency department hallways, both for patients and for themselves. In contrast, ward nurses and those without emergency department experience tended to oppose the placement of patients in hallways, citing concerns related to patient monitoring and privacy. Despite these differences, all groups agreed that medically unstable patients should not be placed in hallways.

The addition of patients to alternate care areas further increases nurses' workloads, contributing to burnout and challenges with retention and recruitment (Lopez, Weerasinghe, & Killackey, 2022). Nursing is inherently demanding and widely recognized as a high-stress profession (Aiken, 2025; CFNU, 2022; RNAO, 2024). When these demands are compounded by staffing shortages and increased workloads, risks to nurses' physical and mental well-being are intensified. Continuous high work demands are a key factor contributing to nurses leaving hospital settings and, in some cases, the profession altogether (Aiken, 2025; CFNU, 2022; Lyu et al., 2024; ONA, 2021; RNAO, 2024).

Another significant contributor to burnout is moral distress, which arises when nurses are unable to uphold professional and ethical standards due to situational constraints (CFNU, 2012;

Haahr et al., 2020; McMillan, 2025; Waterfield & Barnason, 2022). Providing care in hallway environments may conflict with the Canadian Nurses Association Code of Ethics (2025), particularly values related to dignity, relationships, competent care, and privacy. Within these conditions, nurses are constrained in their ability to uphold dignity, ensure privacy, and provide care that is both competent and humanizing. Patients often experience these environments as dehumanizing, and nurses similarly report moral distress associated with delivering care under such conditions. The combined effects of high workload, stressful environments, and moral distress contribute to dissatisfaction and attrition within the profession (Beswitherick, 2022; CFNU & CNA, 2019; McMillan, 2025; Waterfield & Barnason, 2022).While existing literature provides valuable insight, most studies focus on the emergency department. The inpatient setting has been less frequently examined and is often included only for comparison rather than as a primary focus. Additionally, much of the literature emphasizes quantifiable outcomes such as satisfaction, communication, and patient–nurse interactions, rather than in-depth exploration of nurses' lived experiences (Amanzai & Istanboulian, 2025; Chang et al., 2016; Garson et al., 2008; Lee et al., 2018; Lee et al., 2020; Pines et al., 2007; Pulliam et al., 2013; Richardson et al., 2020; Rixe et al., 2018; Stiffler & Wilber, 2015; van Loveren et al., 2021; Viccellio et al., 2009; Villalona et al., 2020). A deeper understanding of nurses' experiences of hallway healthcare is needed to better support practice and protect nurse well-being.

2.5.2 Professional standards and fundamentals of nursing care

Fundamentals of care in nursing encompass the essential interventions required to meet patients' physical, psychological, and relational needs (Ottonello et al., 2023). These fundamentals are a core component of a patient's hospital experience and include elements such as safety, comfort, communication, dignity, mobility, privacy, toileting, and rest (Pentecost et al.,

2020). When these needs are unmet, there are significant consequences for both patients and nurses.

Hallway healthcare challenges nurses' ability to deliver patient-centred care and meet established standards of practice. In Ontario, the College of Nurses of Ontario (CNO) sets the professional standards that nurses must uphold to maintain their licensure. However, hallway healthcare can compromise nurses' ability to meet these standards, potentially affecting both patient outcomes and professional accountability.

The *Code of Conduct Practice Standard* outlines nurses' responsibilities to patients, colleagues, employers, and the public (CNO, 2025). One principle frequently challenged in hallway settings is that nurses must provide safe and competent care (CNO, 2025). Specific expectations, such as responding to patients in a timely manner and being consistently available to those in their care, are difficult to uphold in hallway environments (CNO, 2025). Patients in these settings often report longer wait times and reduced interaction with nurses, illustrating how hallway healthcare can compromise adherence to professional standards (Derlet et al., 2014; Foss & Krogstad, 2000; Villalona et al., 2012). This highlights a broader concern regarding nurses' ability to consistently meet professional expectations in environments not designed for safe, high-quality care.

2.5.3 Nursing systemic and policy concerns

Nurses across Canada have expressed strong opposition to hallway healthcare, citing significant risks to both patients and providers (CFNU, 2009). Working conditions have deteriorated to the point where some nurses report feeling unsafe providing care or even attending work (Woodward, 2024). In 2024, the Canadian Institute for Health Information (CIHI) reported that 67.8% of registered nurses (RNs) and 49.1% of licensed/registered practical

nurses (LPNs/RPNs) were employed in hospital settings. Given these substantial proportions, many nurses are likely to have encountered hallway healthcare in their practice environments (CIHI, 2024).

As hallway healthcare reflects broader systemic challenges, nursing unions have called on provincial healthcare leaders to re-evaluate how overcapacity and chronic congestion are addressed (CFNU, 2022; Canadian Union of Public Employees [CUPE], 2020; ONA, 2007; Seccia, 2013). One proposed strategy to build capacity in the community is to expand the role of nurse practitioners (NPs) in primary care. Many within the profession suggest that NPs could play a leading role as most responsible providers in certain contexts, thereby improving access to care and reducing hospital admissions (CFNU, 2022; RNAO, 2019). Additional strategies include strengthening community-based services, improving access to multidisciplinary providers, and ensuring appropriate staffing levels across care settings (CFNU, 2022).

In summary, the literature indicates that hallway healthcare poses significant challenges to nurses' professional identities and their ability to provide safe, ethical care. A healthy work environment (HWE) is essential to ensuring that nurses are supported and able to practice safely. Addressing this gap in the literature provides an opportunity to better understand nurses' experiences and well-being in inpatient settings.

2.6 Conceptual framework

The conceptual framework guiding this study is the HWE Model (RNAO, 2007). This model was selected because it offers a structured, evidence-based approach for examining complex factors at the individual, organizational, and system levels and how they converge to shape nurses' work environments. At the same time, it remains sufficiently broad and flexible to allow for an open exploration of nurses lived experiences and perspectives within their practice

environments. The model was first used in the six foundational RNAO (2007) best practice guidelines (BPGs). These foundational BPGs were developed to provide the best available evidence for creating and sustaining healthy work environments in the areas of leadership, collaborative practice, workload and staffing, professionalism, embracing diversity, and workplace health, safety, and well-being (RNAO, 2007). There are now nine HWE BPGs, with three additional guidelines added to the original six: violence prevention, fatigue mitigation, and conflict management (RNAO, 2010). The HWE Model (RNAO, 2007) is used across these guidelines to recognize that no single intervention can succeed without change at all levels and that recommendations must be multi-level and interdependent. As such, it provides a valuable lens through which to interpret the findings and consider practical, evidence-based recommendations for improvement.

According to the HWE Model (RNAO, 2007), a healthy work environment is "a practice setting that maximizes the health and well-being of nurses, quality patient/client outcomes, organizational performances, and societal outcomes" (p. 15). This definition aligns with the World Health Organization's conceptualization of a healthy workplace as a setting in which "workers and managers collaborate to use a continual improvement process to protect and promote the health, safety, and wellbeing of all workers and the sustainability of the workplace…" (World Health Organization, 2010, p. 11). As illustrated in Appendix B, the HWE Model (RNAO, 2007) is a systems model comprising three interdependent levels: the individual nurse/worker (micro-level), the organizational/unit (meso-level), and the external/system level (macrolevel). Each level includes three interacting core components: physical/structural/policy, cognitive/psychosocial/cultural, and professional/occupational. Together, these components shape the key recipients of a healthy work environment—patients, nurses, organizations, and

society—which are positioned at the centre of the model. The HWE Model (RNAO, 2007) assumes that a healthy work environment is produced through synergistic interactions among these system levels and their components. In the following subsections, the components of the model are described

2.6.1 Physical/structural policy component

The physical/structural/policy component of the HWE Model (RNAO, 2007) focuses on creating and maintaining safe, well-designed, and adequately resourced work environments that support both staff and patient well-being. It emphasizes the importance of appropriate staffing levels, safe equipment, manageable workloads, and environments that promote comfort, privacy, and safety. This component recognizes that the physical layout and organizational infrastructure of the workplace directly affect nurses' ability to deliver care, prevent injury, and maintain their own health and professional integrity.

This component encompasses external policy factors, organizational physical factors, and the physical demands of nursing work. At the macro-level, external policy factors include healthcare delivery models, funding, and political frameworks that exist outside the organization. In Canada, provinces and territories fund approximately 78% of healthcare costs, with the remainder provided through federal transfers (Canadian Medical Association [CMA], 2023). Despite recent budget increases, the healthcare system continues to face critical nursing shortages, limited primary and community healthcare services, and increasing demand for care (CFNU, 2024). Nurses, as one of the largest groups of healthcare providers, are continually asked to do more with fewer resources (CNA, 2024). To support nurses, professional organizations advocate for targeted measures such as tax benefits and nursing education funding to retain and support the workforce (CFNU, 2024). They also recommend redirecting funding

toward primary and community-based care rather than for-profit services to reduce pressure on hospitals (CFNU, 2024).

At the meso-level, environmental and organizational conditions directly shape the physical workspace and nurses' working conditions. These include the availability and maintenance of equipment, the physical layout of care environments, and overall safety. For example, beds placed in hallways may obstruct movement and often lack immediate access to essential equipment and supplies (McNaughton et al., 2011). Organizational structures such as occupational health and safety policies, staffing ratios, and scheduling systems are also designed to respond to the physical demands of nursing work (RNAO, 2007).

At the micro-level, physical work demand factors refer to the day-to-day requirements nurses must meet in practice. These include shift work, heavy lifting, exposure to hazardous or infectious substances, and personal safety risks. As highlighted in Chapter Two, hallway healthcare exacerbates these risks, increasing the likelihood of verbal and physical violence. Additionally, the absence of room dividers, appropriate isolation, and adequate cleaning stations may contribute to the spread of respiratory viruses and other infections (Richards & Derlet, 2022).

2.6.2 Cognitive/psychosocial cultural component

The cognitive/psychosocial/cultural component of the HWE Model (RNAO, 2007) centers on the emotional, mental, and social climate of the workplace. It includes how nurses experience their roles, relationships, and sense of belonging within their teams. This component emphasizes the importance of a culture grounded in respect, trust, and open communication, where nurses feel supported, heard, and valued. Psychological safety, professional identity, and recognition are essential for enabling nurses to think critically, uphold ethical practice, and

engage effectively in patient care. At the macro-level, broader influences such as social norms, policy, demographics, and public expectations shape healthcare organizations and the experiences of healthcare workers.

At the meso-level, this component encompasses social and organizational factors such as culture, climate, leadership, roles, and communication that influence the work environment (RNAO, 2007). Organizational culture reflects the shared values, attitudes, and behaviours reinforced through both formal policies and informal workplace norms (Pavithra et al., 2022). Pavithra et al. (2022) describe three key dimensions of culture: *being, behaving*, and *belonging.* Within an organizational context, these dimensions relate to identity and purpose (being), patterns of interaction and expectations (behaving), and connection and inclusion within teams (belonging). In nursing, these dimensions are embedded in care pathways, communication practices, and everyday routines, often described by experienced nurses as "the way things are done around here" (Mannion & Davies, 2018, p. 2). The way organizational culture is shaped at the meso-level has a significant impact on nurses' morale, job satisfaction, and overall well-being (Kim et al., 2023; Noth-Matchett & Stoerger, 2025; RNAO, 2013; Zou et al., 2025).

At the micro-level, the focus is on individual and relational factors that influence how nurses think, feel, and behave. Factors such as clinical knowledge, coping skills, job security, and team relationships shape how nurses respond to workplace demands. At this level, the effects of organizational culture are experienced in the day-to-day realities of practice. Attention to meso-level factors such as workload, staffing, and overall work demands can help reduce burnout and improve job satisfaction (Mijakoski et al., 2015). Achieving balance between work demands and available resources is essential. When nurses have manageable workloads, adequate staffing, and sufficient emotional and professional support, they are better able to

maintain their well-being and deliver high-quality patient care (Mijakoski et al., 2015; Wong, 2024).

2.6.3 Professional/occupational component

The professional/occupational component of the HWE Model (RNAO, 2007) focuses on factors that shape nursing as a profession and influence nurses' roles within the Canadian healthcare system. It includes elements such as professional accountability, scope of practice, and workload. Nursing regulations and legislated scopes of practice define the boundaries of what nurses are authorized to perform (CNO, 2025). These scopes are intentionally broad to accommodate variation in patient needs and models of care (CIHI, 2021). While this flexibility is beneficial, it also introduces variability in how roles and responsibilities are interpreted within organizations at the meso-level.

Another example is policies related to nurse-to-patient ratios, which have a direct impact on nurses' workload and patient outcomes (CFNU, 2012). These ratios influence both meso- and micro-level conditions. Research shows that for each additional patient added to a nurse's workload; the likelihood of surgical mortality increases by 7%. Additionally, each additional patient is associated with a 23% increase in nurse burnout and a 15% increase in job dissatisfaction (CFNU, 2012). Mandated nurse-to-patient ratios have been proposed as one approach to addressing chronic staffing shortages and improving workplace safety and job satisfaction (Nova Scotia Nurses Union [NSNU], 2024). Currently, British Columbia and Nova Scotia are the only Canadian provinces that have implemented minimum nurse-to-patient ratios (British Columbia Nurses Union [BCNU], 2024; NSNU, 2024). In British Columbia, a ratio of one nurse for every four patients in medical–surgical units, 24 hours a day, seven days a week, has recently been established (BCNU, 2025).

At the meso-level, regulatory policies are interpreted within organizational structures (CIHI, 2021). For example, according to the CNO (2014), decisions regarding whether care is assigned to a registered nurse (RN) or registered practical nurse (RPN) depend on three factors: the client, the nurse, and the environment. RNs typically manage more complex and unpredictable cases, whereas RPNs care for patients with more stable and predictable needs.

At the micro-level, individual attributes such as knowledge, skills, resilience, adaptability, and moral values influence how nurses respond to workplace demands. The HWE Model assumes that nurses who are supported to practice to their full scope are more confident, engaged, and able to provide care aligned with their professional values (RNAO, 2007). When the work environment does not support these conditions and compromises professional values, nurses may experience moral distress (ONA, 2007).

2.7 Summary

In summary, existing literature on hallway healthcare has primarily focused on emergency departments, where patient overflow and bed shortages are most visible. Policy discussions often emphasize efficiency and capacity management, while studies from patient and family perspectives highlight compromised dignity, privacy, and safety. Research on nurses—particularly in emergency department settings—demonstrates significant moral distress and unsafe working conditions driven by systemic pressures. However, less is known about how these conditions manifest within inpatient settings.

This study seeks to address this gap by exploring **s**urgical nurses lived experiences of hallway healthcare. The HWE Model (RNAO, 2007) provides the conceptual framework and offers a lens for examining how interactions across system levels and components shape nurses'

work environments. The following chapter outlines the methodology used to investigate these experiences.

Chapter 3 Methodology and Methods

3.1 Introduction

In this chapter, I introduce interpretive description (ID) as the qualitative approach guiding my study (Thorne, 2016). This methodology provides a framework for exploring the nuanced experiences of surgical nurses caring for patients in hallways. I begin by outlining the principles of ID and how they inform this research. Next, I describe the research methods, including the sampling strategy, study setting, recruitment process, and approaches to data collection and analysis, in alignment with ID. I also detail the strategies used to enhance the methodological rigour of the study. Finally, I discuss ethical considerations, with particular attention to safeguarding the well-being and confidentiality of study participants.

3.2 Interpretive description

Interpretive description (ID) is a qualitative research approach that, like many other qualitative methodologies, is rooted in the constructivist paradigm. The constructivist paradigm recognizes that while individuals have unique experiences, there are also constructed realities that may be shared among people in comparable situations (Thorne et al., 1997). Constructivism is grounded in the belief that reality is not singular or objective but instead socially constructed and shaped by individual experiences, interactions, and cultural contexts. ID is grounded in a constructivist epistemological foundation and allows for a more holistic and empathetic exploration of lived experiences by embracing the idea of multiple realities. This approach also values the co-construction of knowledge between the researcher and participants, acknowledging that the researcher's own experiences contribute to the interpretive process (Thorne et al., 1997).

While ID borrows techniques from other qualitative approaches and traditions, it is distinct from methodologies such as phenomenology, grounded theory, and ethnography, which have roots in the disciplines of philosophy, sociology, and cultural anthropology (Thorne et al.,

1997). Thorne et al. (1997) argued that, for nursing research to advance, methodological approaches should be designed for the distinct purposes of the discipline of nursing rather than drawn primarily from other disciplines. ID was developed to address the need for a qualitative approach that reflected nursing's unique nature and philosophical foundation, with the goal of generating clinical knowledge applicable to nursing practice (Thorne et al., 2004).

ID assumes that there will always be some prior theoretical knowledge, clinical pattern recognition, or scientific basis informing studies of human health and illness (Thorne et al., 2004). This assumption acknowledges that researchers bring preconceived ideas and understandings to the phenomenon under study. Within ID, reflexivity is the process by which researchers actively examine their own values, beliefs, and potential biases, and consider how these may influence the research process. Reflexivity requires ongoing self-awareness and acknowledgement of the researcher's position within the study. As described in my reflection in Chapter One, I bring to this study both understanding of and experience with hallway nursing in the surgical inpatient setting. My own thoughts and feelings about this phenomenon are part of why I am pursuing this research. These perspectives cannot be separated from my interpretations of the data; rather, they contribute to the depth of the analysis

3.3 Scaffolding

Theoretical scaffolding, as described by Thorne (2016), outlines the conceptual and methodological foundation that supports the structure of a study, ensuring rigour, coherence, and alignment with the research purpose and the researcher's positionality. Several elements contribute to scaffolding a study, including the literature review, theoretical fore-structure, and theoretical baggage (Thorne, 2016). The literature review situates the study within the existing body of knowledge, while theoretical fore-structure and theoretical baggage contribute to

locating the researcher within the chosen field and broader theoretical context (Thorne, 2016). To do so, the researcher must identify their theoretical allegiances within the discipline, as well as their assumptions and perspectives on the phenomenon of interest. Together, these elements illustrate how the researcher's perspectives and actions shape the nature and outcomes of the study (Thorne, 2016).

Reviewing the literature is critical, as it provides insight into what is known, what remains unknown, and the strengths and limitations within the existing body of knowledge (Thorne, 2016). Drawing conclusions from prior research allows the researcher to understand what methods, perspectives, and approaches have already been explored, thereby identifying opportunities for generating new knowledge. As outlined in Chapter Two, much of the existing literature focuses on hallway healthcare in the emergency department. A notable gap in this literature is the limited exploration of nurses' experiences, particularly within inpatient settings. Critically engaging with existing research provides an essential foundation for this study and helps scaffold the exploration of hallway healthcare.

The Healthy Work Environment (HWE) Model (RNAO, 2007), as described in Chapter Two, provides theoretical scaffolding for this study. The model outlines key components of a healthy work environment and the interconnections between macro-, meso-, and micro-level systems. In this study, the HWE Model (RNAO, 2007) offers a framework for understanding how hallway healthcare shapes nurses' experiences at individual and relational levels, while also reflecting broader systemic influences. The model guided the interpretation of findings by illustrating how structural and systemic factors converge to influence nurses' capacity to provide safe and ethical care and to support or undermine a healthy work environment.

Another key element of scaffolding involves understanding what the researcher brings to the study. This includes both theoretical fore-structure and theoretical baggage. Thorne (2016) refers to this process as "locating" oneself within the field and broader theoretical context. In qualitative research, the researcher is recognized as an instrument who plays a meaningful role in shaping the nature and outcomes of the data and findings (Thorne, 2016). This involves: (1) identifying one's theoretical allegiance, (2) situating oneself within a discipline, and (3) articulating one's personal relationship to the phenomenon of interest (Thorne, 2016). These elements are essential for centering both the researcher and the study prior to data collection, ensuring alignment between the researcher, the research purpose, and the intended audience.

The discipline in which I situate myself is nursing. My theoretical allegiance lies with qualitative research, reflecting my appreciation for a constructivist approach and the compassionate, nuanced nature of the nursing profession. In Chapter One, I reflected on my practice, assumptions, and understanding of the phenomenon of interest. I acknowledge that my experiences and perspectives may differ from those of the participants in this study. I remain open to understanding their viewpoints and approach the research process with reflexivity, maintaining ongoing awareness of how my position and assumptions may shape interpretation and meaning.

3.4 Context, sample, and sampling

In ID, a small number of participants can yield sufficient data to address the purpose of the research (Thompson Burdine et al., 2020). Various sampling methods may be used in ID, and the use of more than one method is encouraged (Thorne, 2016). Purposeful sampling was used to recruit individuals who were knowledgeable about or had experience with the phenomenon of interest. The inclusion criteria were as follows: (1) RNs or RPNs currently working, or who had

previously worked, full-time, part-time, or casually on an inpatient surgical unit in Ontario; (2) experience with hallway healthcare; and (3) English-speaking, as the principal investigator speaks English only. Snowball sampling was also used to support purposeful recruitment of individuals who met the inclusion criteria. At the end of each interview, participants were invited to share the researcher's contact information with others who might be interested in participating.

In ID, sample size is determined by the amount of data needed to address the research aims (Thorne, 2016). Because data collection and analysis occur concurrently, the researcher can assess when the sample is sufficient to meet those aims. To gain a rich and nuanced understanding of hallway healthcare from the perspectives of surgical nurses, I initially estimated that 10 to 12 participants would be needed. However, given the richness of the data collected, nine participants were sufficient.

Recruitment was conducted entirely through social media. An electronic leaflet (Appendix C) containing information about the study, eligibility criteria, and the researcher's email address was shared on several nursing Facebook pages, including Canadian Medicine Surgery Nurses, Ontario Nurses United, and Travel Nurses Canada. The leaflet was posted using my personal Facebook account, and viewers were encouraged to share it with others. Using an opt-in approach, individuals interested in participating contacted the principal investigator directly by email. For individuals referred by other participants as part of snowball sampling, the study, inclusion criteria, and any questions were discussed. Eligible individuals who agreed to participate were sent the informed consent form (Appendix D) prior to the interview. Participants were then given the option of returning the completed consent form in advance or, after reviewing the form, providing verbal consent before the interview began.

3.4.1 Data collection

Common data collection techniques in qualitative research include interviews, focus groups, and observations (Thomas Burdine et al., 2020). For this study, data were collected through one-on-one virtual interviews conducted with participants via audio calls on Microsoft Teams. Virtual interviews offered greater convenience for participants and made it possible to interview individuals from across Ontario. The interviews were semi-structured and guided by broad questions and prompts (see Appendix E). The use of broad questions allowed participants to focus on what they felt was most important about their experiences with hallway healthcare. Although the questions were not explicitly linked to the HWE Model (RNAO, 2007), they were designed to explore how nurses' work environments might be shaped by factors operating at multiple levels. In addition, demographic questions were asked to describe the sample (see Appendix E).

3.4.2 Data analysis

As noted earlier, data collection and data analysis occur concurrently in ID, creating an iterative process (Thorne, 2016). An approach consistent with Braun and Clarke's (2022) thematic analysis was used. This analytic method is a reflexive and iterative process consisting of six phases: (1) familiarizing oneself with the data, (2) generating codes, (3) generating initial themes, (4) reviewing themes, (5) defining and naming themes, and (6) locating exemplars (Braun & Clarke, 2022). Following these phases helps identify and report patterns within the data (Scharp & Sanders, 2018). Although these phases are presented linearly, thematic analysis is not a unidirectional process (Braun & Clarke, 2022). The scaffolding described in Chapter Three also influenced the analysis. The foundation of this study was informed by my own experiences of hallway healthcare, along with insights drawn from the literature, both of which shaped how I

interpreted the data. Movement between phases occurred as I continued to learn from and analyze the data.

Thematic analysis is flexible, allowing for a detailed and nuanced analysis of data. A key principle of this method is that themes do not simply "emerge" from the data; rather, they are actively interpreted and developed by the researcher (Braun & Clarke, 2022). Interview data were transcribed verbatim to facilitate analysis. The analysis began with repeated readings of each transcript to develop a comprehensive understanding of participants' experiences. Each transcript was analyzed in its entirety, and notes were made regarding initial impressions. From these initial impressions, codes, or meaning units, were developed across and within transcripts using constant comparison. These initial codes were then organized into preliminary themes and subthemes. The themes captured patterns that were important to the data in relation to the research question (Braun & Clarke, 2022). The preliminary thematic structure was discussed with my thesis supervisor to refine the themes. Through this collaborative process, consensus was reached regarding the themes, subthemes, thematic organization, and interpretations of the data. The developing analysis was then shared with thesis committee members, along with selected transcripts, to ensure coherence and consistency between the data and the preliminary interpretations

3.4.3 The conceptual framework in the analytic process

The RNAO Healthy Work Environment conceptual framework was used as an interpretive lens rather than a fixed structure imposed on the data. Initial coding was completed inductively and remained grounded in participant accounts. As patterns were identified, the framework was used to further interpret these experiences across different system levels. In this way, the

framework helped situate participant experiences within broader structural contexts and supported consideration of where potential interventions might be most meaningfully directed.

3.5 Methodological rigour

Attention to methodological rigour in ID is important in both the research process and the reporting of that process (Thorne, 2016). ID acknowledges that bias cannot be fully eliminated because nursing research is shaped by inherent disciplinary perspectives (Thorne et al., 1997). For example, the view that all people deserve access to health resources is a value that shapes nursing research interpretations and is integral to nursing philosophy (Thorne, 2016). To enhance rigour, I practiced reflexivity by examining how my personal background, assumptions, and potential biases might influence the research. Throughout the study, I kept a reflexive journal to document my thoughts, reactions, and any shifts in perspective as I collected and analyzed the data. This journal served as a tool for self-awareness and helped me remain mindful of how my position on hallway healthcare may have shaped the findings. I also sought regular feedback from my thesis supervisor and thesis committee to identify unnoticed biases and gain an external perspective. In addition, any influence or bias was explicitly acknowledged in the findings.

Methodological rigour in ID extends beyond traditional qualitative criteria because of the applied and practice-oriented aims of the methodology (Thorne, 2016). For qualitative research to be rigorous, researchers must understand what the chosen method is designed to produce, as well as the social and practical context in which the research will be shared. This reflects the recognition that findings may inform practice and be used in applied settings (Thorne, 2016). Thorne (2016) identifies four evaluative criteria that support methodological rigour in ID: *epistemological integrity, representative credibility, analytic logic,* and *interpretive authority.*

3.5.1 Epistemological integrity

In qualitative research, it is important that the ideas, questions, and context fit together logically. To enhance the credibility and trustworthiness of the study, any assumptions and methodological decisions should be explicitly reported (Thorne, 2016). *Epistemological integrity* is the principle that the research process and findings align with the research question and study methodology (Thorne, 2016). This study demonstrates strong methodological coherence, with the research design, ID approach, interview format, and analysis. Purposefully aligned to reflect the study's conceptual foundation and aims. To demonstrate this, researchers must thoroughly and thoughtfully report their epistemological positions as well as the decisions that respect their stance (Thorne, 2016). To enhance credibility and trustworthiness of the study, any assumptions and choices made are explicitly reported in the research process.

3.5.2 Representative credibility

Representative credibility refers to whether the findings reflect not only the perspectives of participants but also the broader population of interest (Thorne, 2016). To support this, theoretical claims should align with the sampling strategy used to explore the selected phenomenon. This helps ensure that interpretations remain grounded in the context and characteristics of the data collected. In this study, representative credibility was supported through broad sampling criteria and the inclusion of nine participants. All Ontario RNs and RPNs with experience caring for surgical hallway patients were eligible to participate. This approach allowed for a range of geographical and professional perspectives. Nursing designation and years of experience were also considered, as these factors may influence how participants interpret their work environments. Attention to variation in participant characteristics and context supported the inclusion of a range of perspectives in the study sample.

3.5.3 Analytic logic

Analytic logic refers to the visibility of the reasoning process used to move from data to interpretation (Thorne, 2016). In qualitative research, readers should be able to follow how the analysis was conducted and how interpretations were developed. To support analytic logic, an audit trail was maintained throughout the study. This included documentation of analytic decisions, coding, sub-theme and theme development, and interpretive discussions. Maintaining this record supported transparency in how the analysis progressed from interview data to the final interpretive structure. In addition, anonymized participant quotes were retained for use in the findings chapter to illustrate the connection between the data and the interpretations presented.

3.5.4 Interpretive authority

Interpretive authority refers to the extent to which the researcher's interpretations are grounded in the data rather than based primarily on personal bias (Thorne, 2016). While ID acknowledges the researcher's prior knowledge and subjectivity, it also requires that interpretations be supported by clear evidence and remain appropriate to the context of the study. This involves distinguishing between individual accounts and patterns of shared meaning, while also acknowledging the researcher's influence on the interpretive process. In this study, interpretive authority was supported through reflexive journaling, regular discussions with my thesis supervisor (CM), and collaborative review with thesis committee members (BV and KM). These processes provided opportunities to examine assumptions, question developing interpretations, and ensure that analytic claims remained closely aligned with participant accounts. Together, these strategies supported transparency in how interpretations were constructed.

3.6 Research ethics

Ethical approval was obtained from the University of Ottawa Research Ethics Board (REB), file number H-03-25-10934. Because recruitment used an opt-in approach, individuals interested in the study contacted the principal researcher directly by email to discuss the study and confirm eligibility. The principal researcher then emailed the informed consent form (refer to Appendix F) to allow individuals time to review it prior to their interview. Participants had the option of returning the completed consent form by email or providing verbal consent before the start of the interview. All participants opted to provide verbal consent.

Interview transcripts, notes, and any other study-related materials were stored in the principal researcher's University of Ottawa Microsoft OneDrive account. This account is password protected and requires two-factor authentication. As described in Section 3.4, interviews were conducted through audio calls using Microsoft Teams, an encrypted platform that permits the recording and transcription of interviews. Data from the Microsoft Teams interviews were stored in the principal researcher's University of Ottawa Microsoft OneDrive account. Only the principal researcher (ZR) and thesis supervisor (CM) had access to the folders containing the interviews and participants' personal and demographic information, which were stored in separate files. Interview transcripts were de-identified before being shared with thesis committee members (KM and BV). Participants were assigned a unique identification number to protect their identity. In accordance with REB requirements, data will be retained for five years following completion of the study.

Chapter 4 Findings

Chapter 4 is formatted as a manuscript for submission to a peer-reviewed nursing journal.

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Statements and Declarations: Not Applicable

Ethical Considerations: The study was approved by University of Ottawa Ethics Review Board, H-03-25-10934 on March 25, 2025. Informed consent was obtained verbally before data collection. Verbal informed consent was audio-recorded.

Consent to participate: All participants reviewed the written informed consent form and provided audio-recorded verbal consent prior to their interview.

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Surgical Nurses' Experience of Hallway Healthcare

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Abstract

Background: Hallway healthcare refers to the practice of providing patient care in hospital hallways. Although traditionally associated with overcrowded emergency departments, this practice has increasingly extended into inpatient units as a strategy to alleviate chronic overcrowding and enhance patient bed flow. This study explores nurses lived experiences of providing hallway healthcare in the inpatient surgical environment.

Methods: A qualitative study, guided by interpretive description, was used to explore the experiences of nurses working in surgical in-patient settings in Canada. Purposeful sampling was used to recruit nine nurses with direct experience of hallway healthcare. Data was collected through individual semi-structured interviews and analyzed thematically to identify key patterns in the data reflecting the focus of the inquiry.

Results: Three main themes were identified: *Part of the Job, Constrained in Care and Voice*, and *Relational Disruption.* Rather than a temporary strategy to facilitate bed flow, hallway healthcare was routine. Driven by organizational top-down decisions, participants' practice was constrained into spaces unsafe for practice. The presence of patients in hallways, alongside overextended staff, eroded trust, strained relationships, and ultimately compromised the quality-of-care participants felt they were able to provide.

Conclusion: The findings add support to the growing literature on the adverse impact of hallway healthcare and the need for healthcare systems and organizations to move beyond it by investing in capacity, workforce, and environments that enable safe, ethical, and dignified practice.

Key words: hallway healthcare, hallway medicine, hospital overcrowding, patient safety, nurse-patient relations, nurse well-being.

Background

In Canada and around the world, healthcare systems are under increasing pressure from the rising number of patients requiring hospital admission (Feldman, 2020). As a result, patients arriving at the emergency department often encounter lengthy wait times and overcrowded conditions. It is common for patients to receive care in hallways in attempts to improve patient flow and address bed shortages (Lopez et al., 2022). *"Hallway healthcare,"* also known as *"hallway medicine,"* refers to the provision of care to patients in hallways and falls under the broader term *"alternate care areas"* (De Leon et al., 2020; Lee et al., 2020). These alternate care areas may include conference rooms, endoscopy suites, and other non-traditional spaces where patients are admitted when no designated inpatient bed is available (Lee et al., 2018). Although overcrowding is most visible in the emergency department, hallway healthcare is not confined to this setting and extends into inpatient units. While evidence points to the negative impacts of hallway healthcare on nurses in the emergency department (Ahmed et al., 2024; Amara, 2024; Villalona et al., 2020), limited attention has been given to how it shapes nurses' working environments in inpatient contexts and the implications for nurses' practice and wellbeing. This inquiry focuses on nurses within the surgical inpatient setting.

Drivers of hallway healthcare

To understand why hallway healthcare is occurring, it is important to examine broader contextual factors that contribute towards it. A major system level factor underlying hallway healthcare is the growing demand on health services along with finite resources allocated to meet these demands. This strain on inpatient healthcare reflects multiple intersecting factors, including advances in medicine and treatments, an aging population, and inadequate primary healthcare and community resources (HomeCare Ontario, 2024; Ontario Hospital Association, 2019;

Ontario Health, 2019). A shortage of primary care physicians adds to the pressure on hospitals, leaving many Canadians without a family doctor and reliant on the emergency department for non-urgent medical needs (Canadian Institute for Health Information [CIHI], 2024). As a result, hospitalizations in Canada are rising. In 2023–2024, there were 3.05 million hospitalizations in Canada, an increase from 2.96 million in the previous year (CIHI, 2025a). This trend is closely related to population aging as older adults (65 years and above) are more likely to have chronic conditions that require hospital admissions, undergo surgeries and experience longer hospital stays (CIHI, 2025a). Since the pandemic, surgeries for older adults increased by 19%, the highest increase for any age group (CIHI, 2025c). As the projected proportion of older adults in Canada increases to one-fourth of Canada's overall population by 2040, the demand for hospital and community services will continue to rise (Public Health Agency of Canada, 2020). Within the surgical context, this demand is particularly evident. Osteoarthritis, for example, is the most common cause of inpatient surgery in older adults, leading to a high demand for knee and hip replacements (CIHI, 2025a). The recommended wait time for hip and knee replacements is six months; however, in 2024 only 68% of hip replacements and 61% of knee replacements were completed within this timeframe (CIHI, 2025b). This represents a decline from five years earlier, when 75% of hip replacements and 70% of knee replacements met the six-month benchmark (CIHI, 2025b).

Further compounding hospital overcrowding is the growing number of patients identified as requiring *alternate level of care* (ALC). These patients no longer need acute in-patient care but remain in hospital while waiting for an appropriate placement or home care services (CIHI, 2016). This places significant strain on hospital capacity, as beds are occupied by patients awaiting discharge. Contributing to these delays are insufficient community services, staffing

shortages, and underfunding, which have led to growing waitlists for placements and home care (CareFor, 2024; City of Ottawa, 2025; CIHI, 2025d). In Ontario, for example, older adults wait an average of 125 days for admission to long-term care, with some waiting up to two and a half years (Ontario Long-Term Care Home Association, 2023). These pressures underscore the multiple factors driving hospital overcrowding and reinforce the urgent need for major investments in healthcare infrastructure and resources across primary, tertiary, and community care (Cheese, 2024; Health Quality Ontario, 2023; Ontario Health, 2019; Ontario Long-Term Care Home Association, 2023).

At the organizational level, responses to overcapacity are typically operational and centred on policies and procedures to manage patient bed flow. Centralized bed management and strategies to accelerate patient discharge and transfers are common (Alishahi Tabriz et al., 2019; Kreindler et al., 2020; Ontario Health, 2022). Within these overcapacity protocols, hallway healthcare functions as an overflow approach, offloading admitted patients from overcrowded emergency departments (Kreindler et al., 2020). However, these policies prioritize efficiency and can obscure the human costs for staff and patients.

Impacts of hallway healthcare

Mainstream media reports highlight the harrowing experiences of patients receiving care in hospital hallways (Buffam, 2024; Butler, 2022; Cheese, 2024; Favaro, 2023; Skulski, 2024). Research similarly indicates that hallway healthcare undermines patient safety, communication, the timeliness and effectiveness of treatment, and satisfaction with care (Chang et al., 2016; Richards & Derlet, 2022; Lee et al., 2018; Lee et al., 2020; Pines et al., 2007; Richardson et al., 2020; Stiffler & Wilber, 2015; Viccellio et al., 2008). These impacts are closely tied to the delivery of care within hallway spaces. As healthcare providers with the most direct patient

contact and primary responsibility for day-to-day care, nurses are central to how hallway healthcare is enacted and experienced, making it essential to understand how these conditions affect their practice and wellbeing.

Research examining hallway healthcare from nurses' perspectives has focused on the emergency department. Studies show that nurses struggle to deliver safe, ethical, and person-centred care in these environments because of limited space, lack of privacy, and continuous workflow interruptions (Chang et al., 2016; Villalona et al., 2020). As a result, nurses can feel dissatisfied with the care they provide and with their ability to develop therapeutic relationships with patients and families (Chang et al., 2016; Villalona et al., 2020). Although this research provides valuable insights, the predominant focus on the emergency department, overlooks the experiences of nurses within hospital inpatient units. While hallway healthcare may present similar challenges to nurses across care settings, each clinical environment is shaped by distinct contextual demands. Therefore, it is essential to examine hallway healthcare within the unique contexts that it occurs and from the perspectives of nurses within that setting.

When patients are placed in hallways their confidence and trust in the healthcare system can start to dissipate, negatively affected therapeutic relationships and contributing to their breakdown (Chang et al., 2016; CFNU, 2009; Pines et al., 2007; Richardson et al., 2020; Villalona et al., 2020). As a result, nurses can feel dissatisfied with the care they provide and their ability to connect with patients. This relational strain can also contribute to distrust and frustration expressed by patients in hallways can escalate into harassment and violence toward nurses (Ahmed & Bourgeault, 2022; ONA, 2021). At the same time, the addition of patients in alternate care areas further increases nurses' workloads, contributing to burnout, and challenges with nurse retention and recruitment (Lopez et al., 2022). Nursing is inherently challenging and

recognized to be a high stress profession (Aiken, 2025; Ahmed & Bourgeault, 2022). When these demands are compounded by staff shortages and increased workloads, the risks to nurses' physical and mental well-being are increased. Indeed, continuous high work demands are a key reason nurses are leaving the hospital setting, and the profession altogether (Aiken 2025; Ahmed & Bourgeault, 2022; Lyu et al., 2024; ONA, 2021). Another contributing factor to burnout and stress is the moral distress of being unable to maintain professional and ethical standards due to situational constraints (CFNU, 2012; Haahr et al., 2020; McMillan, 2025; Waterfield & Barnason, 2022). Together, the culmination of a high stress environment, increased patient workload, and moral distress has left nurses dissatisfied and leaving the profession (Beswitherick, 2022; CFNU & CNA, 2019; McMillan, 2025; Waterfield & Barnason, 2022).

Research aims

The aim of this study was to gain a deeper understanding of hallway healthcare from the perspectives of surgical nurses. The research question guiding this study is: *What are the experiences of surgical nurses caring for patients in hallways?* This study is situated within surgical inpatient settings, where patient acuity is high and patient turnover is rapid. Surgical units often operate at full capacity due to demand for both elective and emergency surgical procedures, which is intensified by limited operating room availability and a shortage of specialized staff (Kaplan & McGinnis, 2015). Nurses in these settings require specialist knowledge specific to their surgical specialty, including pre- and post-operative recovery and monitoring for potential surgical complications (Pepe & Altmiller, 2024). For surgical nurses, hallway care may be experienced differently, given the intensity of post-operative care and the added demands of heavier patient assignments.

Methods and procedures

Design

Interpretive description (ID), a qualitative design, was chosen as the methodology for this study. Rooted in a constructivist epistemological foundation, ID facilitates a holistic exploration of lived experiences (Thorne, 2016). Developed to address the need for a qualitative approach reflective of nursing's unique nature and philosophical basis, ID aims to derive clinical knowledge that is directly applicable to nursing practice (Thorne et al., 2004). This approach values the co-construction of knowledge between the researcher and participants, acknowledging that the researcher's beliefs and experiences are integral to the interpretive process (Thorne, 2016). Consistent with this perspective, ID assumes that prior theoretical knowledge, clinical pattern observations, or scientific foundations inform studies of human health and illness (Thorne, 2016). As a surgical nurse with lived experience of hallway healthcare, the first author recognized that her perspectives and experiences influenced interpretation of the data. Acknowledging this potential influence, reflexivity was practiced throughout the research process with ongoing self-awareness and the maintenance of a reflexive journal. All authors are registered nurses with professional experience in acute and critical care settings.

Sampling, sample, and setting

A purposeful sampling approach was used to recruit participants who could provide rich insights into hallway healthcare. The inclusion criteria were as follows: 1) RN (registered nurse) or RPN (registered practical nurse) working or have previously worked full-time, part-time, or casually on an inpatient surgical unit in Ontario, Canada, 2) nurses who provided care to patients admitted to hallways in inpatient surgical units, and 3) English-speaking. Snowball sampling was also used to identify additional participants meeting the inclusion criteria. Consistent with ID, the

sample size was determined by the depth and breadth of data required to address the research aims (Thorne, 2016). The final sample comprised nine nurses from across Ontario, Canada, including one registered practical nurse (RPN) and eight registered nurses (RNs), one of whom had transitioned from RPN the year prior. Participants worked across a range of hospital settings, including two from smaller community hospitals and seven from large urban hospitals. Surgical specialties included orthopedics, general surgery, and thoracic surgery. Participants ranged in age from 22 to 40 years and in experience from new graduates to 20 years of practice, reflecting perspectives shaped by varying levels of expertise. Two participants were internationally educated nurses. Geographically, participants were drawn from across Ontario, with one from Northern Ontario, two from Southern Ontario, and six from Eastern Ontario.

Recruitment

Ethical approval was obtained in March of 2025 from the University of Ottawa Review Ethics Board (file number H-03-25-10934). Participants were recruited via social media. An electronic recruitment post outlining the study, eligibility criteria, and the researcher's contact information was shared on various nursing Facebook pages including *Canadian Medicine Surgery Nurses, Ontario Nurses United,* and *Travel Nurses Canada.* Using an opt-in approach, individuals interested in participating contacted the first author directly via email. Eligible participants who agreed to take part were sent the informed consent form, which they could sign and return electronically or provide verbal consent prior to the interview. In all cases, verbal consent was confirmed at the beginning of each interview.

Data collection

Data collection was conducted by the first author through one-on-one virtual interviews using Microsoft Teams. Interviews were conducted between April and June 2025. Demographic

questions were included to describe the sample. A semi-structured interview format was used, with broad, open-ended questions and prompts to encourage participants to explore their experiences and perspectives in depth. The interviews focused on surgical nurses' experiences providing care in hallways, the impact on their roles and well-being, and their views on patient care. Keeping the questions broad allowed participants to focus on what they felt was most important.

Analytic approach

The interview data were transcribed verbatim to facilitate analysis. Data were analyzed using an approach consistent with Braun and Clarke's (2022) reflexive thematic analysis and aligned with the interpretive aims of interpretive description. Analysis began with repeated reading of each transcript to develop familiarity with the data and gain a comprehensive understanding of participants' experiences. Each transcript was analyzed in its entirety by the first author, who documented initial impressions. Comparisons across and within transcripts informed the generation of initial codes or meaning units that captured aspects of the data relevant to the research question (Braun & Clarke, 2022). These initial codes and interpretations were then developed into preliminary themes and sub-themes in consultation with the second author. The preliminary thematic structure and descriptions of the themes and sub-themes were then shared with the other co-authors, along with selected transcripts. This process enhanced coherence and consistency between the data and the developing analytic interpretations. Through collaborative discussion, consensus was reached on the final themes, sub-themes, and overall thematic organization of the data and interpretations.

Methodological rigour

Attention to methodological rigour in ID is embedded in both the research process and the reporting of that process (Thorne, 2016). The first author maintained a reflexive journal throughout the study. The journal, along with regular meetings with the second author, supported ongoing awareness of the first author's clinical background and personal positioning in relation to hallway healthcare. Methodological rigour was guided by Thorne's (2016) four evaluative principles: epistemological integrity, representative credibility, analytic logic, and interpretive authority.

Epistemological integrity refers to coherence between the research question, methodological approach, and analytic strategies (Thorne, 2016). In this study, it was reflected in the alignment between the research question exploring surgical nurses' experiences of hallway healthcare, the use of interpretive description, the semi-structured interview format, and the analytic strategies used to address the study aims. Assumptions and methodological decisions were explicitly reported, allowing readers to assess the coherence and plausibility. Representative credibility concerns whether findings meaningful reflect the phenomenon across the range of participants sampled (Thorne, 2016). This was supported by broad inclusion criteria encompassing both RNs and RPNs across Ontario with experience caring for patients in hallways within surgical inpatient units. Participants varied by hospital setting, years of experience, gender, and surgical specialty, allowing for multiple perspectives to be captured. Analytic logic refers to the transparency of the reasoning process linking data to interpretation (Thorne, 2016). Thorough and systematic documentation of analytic decisions, sub-theme and theme development contributed to analytic logic. The inclusion of participant quotes in the findings also allowed readers to trace how analytic claims were grounded in the data. Interpretive

authority refers to the extent to which analytic conclusions are supported by the data rather than opinion (Thorne, 2016). Within ID, disciplinary knowledge is recognized as a resource, but interpretations must remain grounded in participant accounts. In this study, sub-themes and themes were developed through iterative discussion between the first and second authors and reviewed alongside selected transcripts with the third and fourth authors to ensure coherence between data and interpretation.

Results

From the analysis, three overarching themes were developed, each comprising two sub-themes. The first theme, *Part of the Job,* includes the sub-themes *It's Not a Temporary Fix—It's a Model* and *Making It Work No Matter the Cost.* The second theme, *Constrained in Care and Voice,* comprises the sub-themes *We're Not Part of the Conversation* and *Unsafe by Design: Constrained in Practice.* The third theme, *Relational Disruption,* incorporates the sub-themes *They Think We Don't Care, but We Do* and *Everyone's Already Drowning.* Collectively, these themes and sub-themes reflect the perspectives and experiences of the surgical nurses who participated in the study as they navigated the realities of hallway healthcare in their practice.

Part of the job

The theme of *Part of the Job* reflects how participants viewed hallway healthcare and their experiences navigating it in practice. What was once an infrequent and temporary solution to patient overflow during high-demand periods has become the norm, reshaping how participants delivered care and affecting them and their work. As part of this shift, participants described being expected to take on greater workloads and responsibilities, a change they framed as simply "Part of the job." This theme is explored through two sub-themes: *It's not a temporary fix—it's a model* and *Making it work no matter the cost.*

It's not a temporary fix—it's a model

Participants recalled that before the COVID-19 pandemic, placing patients in hallways rarely happened. It was viewed as a last resort, occurring once or twice a year during periods of high demand, and for some, not regarded as a viable option at all. As one participant explained: *"When I started nursing 11 years ago, there was no space for extra patients outside their rooms. It [hallway health care] was not even considered"* (Participant 2). During the COVID-19 pandemic, participants saw hallway healthcare as a necessary but temporary solution to the unprecedented demand for beds. However, those who had worked before the pandemic noticed a significant increase in hallway placements following the pandemic.

> *"I remember when it [hallway healthcare] was more noticeable. When there was an influx of patients, we would have to try to move someone into an unconventional space. But after the pandemic, it became like a norm—almost like an expectation"* (Participant 4)

For participants who entered the nursing workforce during the COVID-19 pandemic, hallway healthcare was the norm. However, there was an expectation that hallway placements would be phased out as the numbers of patients declined post-pandemic. Instead, participants noticed that since the pandemic, the use of hallways has become commonplace. To the extent that participants described hallway healthcare as so frequent and expected that it had become a normalized "model" to deal with overcapacity, rather than a temporary solution. Although participants recognized that hallway healthcare increased patient flow through their units and hospitals and helped ease the backlog of patients waiting to be admitted from overcrowded emergency rooms, it had a significant cost.

> *"Hospitals are under pressure, and the administrators are trying to make the best of moving patients through the system, which is obviously a huge challenge. It is serving its purpose, but not without cost."* (Participant 3).

While participants acknowledged the need for creative solutions to address these systemic pressures, they emphasized that hallway healthcare is not a sustainable fix.

Making it work no matter the cost

For participants, the normalization of hallway healthcare was not simply adapting to difficult conditions; it was being expected to "make it work" without added resources. After the COVID-19 pandemic, participants described being asked to do more and adapt in ways that came at a cost: *"It hasn't been a good thing, and for me, it's been especially challenging and exhausting"* (Participant 2). Many felt that the resilience they had shown was taken for granted, leaving frontline workers to absorb the consequences of a failing system.

> *"We can only do so much as nurses before we become burnt out. Overworking us is not the solution, system-wide changes need to happen before anything improves"* (Participant 5).

The seemingly insoluble nature of the problem left participants resigned to what they described as a "normalized crisis"*: "In the end, you just continue this cycle, because it's been made clear there's nothing else to do to improve it, so we just make do"* (Participant 4). Being expected to "make it work" meant unsafe nurse-to-patient ratios, missed breaks and meals, extended hours, and physical and emotional strain. Participants spoke of the potential health risks to themselves from working in cramped spaces, dealing with unrelenting stress, and a sense of carrying the system's failures: *"You feel like you're carrying the weight of a broken system without support*

from your management" (Participant 4). Participants witnessed compromises to patient care and expressed concern about patient safety, citing risks of errors, and infection.

> *"God forbid anything serious or life threatening to the patient happen, we would still get in trouble even though we were stretched thin and voiced our concerns"* (Participant 6).

Guilt, burnout, and moral distress were common, leaving participants exhausted, defeated, and numb. As one nurse stated: *"It just makes you not want to come to work"* (Participant 7). Participants emphasized that the stress was not temporary; it reshaped how they viewed their profession, their level of job satisfaction, and their trust in leadership. They felt the emphasis within their organizations was on bed flow management and hallway healthcare as a solution, despite its impact on patient care and nurse well-being. While participants' commitment to patient care remained strong, they recognized that their resilience in "making it work" sustained a broken, underfunded system struggling to meet the increasing demand for hospital beds. As one participant reflected on the situation: *"Someone has to care for the patient no matter what, so in the end, it feels like a losing situation for everyone involved"* (Participant 4).

Constrained in care and voice

Administrative and management decisions significantly shaped the conditions of care delivery, reflecting a top-down approach that excluded participants from decisions about placing patients into hallways. Working within these constraints often came at the expense of nurses' well-being, as hallway care created physically unfit environments lacking the basic infrastructure needed for safe practice. This theme is explored through two sub-themes: *We're not part of the conversation* and *Unsafe by design: constrained in practice.*

We're not part of the conversation

Participants described how hallway healthcare decisions were made with little if any input, from them, yet the consequences of the decisions became their responsibility. They emphasized a top-down structure in which management or administrators responsible for bed flow made patient placement calls, often without fully understanding the conditions on the surgical units. These left participants feeling powerless and excluded from critical decisions affecting their work.

> "*No discussion, no asking how we are managing, nothing, you don't really have a say, cause the hospital is full, likely understaffed and over capacity. So, you have no choice basically."* (Participant 1).

Participants reported they were typically excluded from the decision-making process: *"they [bed managers] just show up, and we say where this patient is going to go? Then it's like, oh, I realize he's going to the hallway"* (Participant 7). Those participants who mentioned being consulted by management and administrative personnel, stated that it did not happen often, and when they were, they felt pressure to accept patients in hallways. This meant moving patients already in beds within rooms into the hallway to free space for new admissions to their units.

> "We *will have to find someone else in a room that is hallway appropriate and switch them if we can. So, it doesn't really help our workload, it just moves patients around"* (Participant 6).

Moving patients into hallways was highly disruptive, and participants were often placed in the uncomfortable position of having to explain and justify these decisions to patients and families, even when they disagreed. A significant concern among participants was the clinical

appropriateness of patients allocated to hallway spaces and potential implications. Although there was an implicit assumption that only patients who were medically stable would be put in hallways, most participants stated that there were no explicit guidelines and decisions were not always consistent and reasoning clear.

> *"I don't know if we have a policy or procedures. No one has shown me anything about the proper procedure or equipment, criteria, any of that. And we get hallway patients all the time"* (Participant 5).

Only one participant reported an awareness of an official hallway placement policy, which outlined the circumstances under which patients were deemed suitable for hallway placement. However, this participant also noted that the policy lacked several critical criteria. For example, the policy did not state whether patients needing oxygen should be excluded, even though it is a key consideration. Further, bed flow in the surgical context was considered more challenging given the high turnover of patients admitted and discharged following surgery. Participants acknowledged the challenges faced by bed management staff, with one participant having prior experience in the role and inherent difficulties involved. Even though participants expressed understanding of the situation, their stories revealed the emotional burden and ethical issues tied to working with limited control, a stark contrast to the ideal of an ethical and supportive workplace.

Unsafe by design: constrained in practice

Participants described how hallway healthcare creates environments that are physically unfit for nursing care. These makeshift spaces lack the essential infrastructure required to provide safe and quality surgical nursing care. Participants also viewed the hallway's physical environment as restricting and limiting their ability to provide quality nursing care. One

participant described the moral tension of wanting to deliver safe care while being stripped of the tools and environment to do so.

> *"It is a frustrating situation where I want to provide safe, respectful care, but I do not have the tools or environment to do so. So, it's disheartening to me, truthfully. This is just how it is, and it makes me feel powerless and undervalued"* (Participant 1).

The physical environment also created safety hazards and workflow challenges. Participants described additional physical demands, constant interruptions, and unsafe conditions that jeopardized both patient and nurse safety. Hallways heightened risks during emergencies, as confined areas and access to equipment were thought to hinder rapid responses: *"We just don't have everything readily available. It could be dangerous"* (Participant 4). Even routine care was burdensome as equipment (e.g., walkers, temporary partitions, beds), crowded the hallways, so participants had to maneuver obstacles, increasing their risk of injury: *"we try our best for patient safety and staff safety as well. But it doesn't always take priority when the hospital is full"* (Participant 5).

The lack of readily available resources, critical in the surgical care context, such as in-wall oxygen and suction, was a major concern. Participants described improvising, for example, using portable oxygen tanks. This equipment further crowded the hallway and required frequent monitoring to ensure that the supply did not run out, adding more critical tasks for the nurses. Within the surgical environment, the prevention of post-operative infections is of critical importance. As hallways are high traffic areas participants worried about patients' exposure to infection. They described the moral weight of carrying out procedures such as wound dressing changes and catheter insertions in the hallways and putting patients at risk of infection. Reducing the risks sometimes meant closing off the area, which disrupted unit activities.

> *"My request to close off the hallway for just a few minutes for a dressing change wasn't a big ask. I just want to keep the sterility of the field to prevent infection, and I wasn't even able to do that, but at the same time I also understand that everybody else also has tasks to do too"* (Participant 5).

The design of hallways as passageways through units and hospitals did not foster an environment that was beneficial for patient care. Privacy was absent, though participants would create makeshift screens, which offered some protection to patients. However, temporary screens did not prevent sensitive conversations from being overheard in the busy hallways effectively undermining patient confidentiality. Participants expressed that these conditions affected every aspect of care. Besides lack of privacy, the noise and lighting in the hallways disturbed patients rest and sleep, and facilities such as bathrooms were less accessible. Incidents of harm and near misses were recalled. One participant reported that a patient in her care sustained a head injury and concussion after a painting fell from the hallway wall. Further, the lack of patient indicators such as whiteboards made it difficult for doctors, families, and other team members to locate patients and restricted healthcare team communications:

> *"Not having a patient's whiteboard to update their plan of care and care team doesn't help. Sometimes doctors don't know where the patient is at all"* (Participant 6).

Relational disruption

The theme *Relational disruption* captures the interpersonal consequences of providing care in hallway spaces. As described in the sub-theme *Unsafe by design: constrained in practice,* the hallway was thought unsuitable for patient care. Participants spoke about how hallway conditions disrupted their ability to build trusting relationships with patients and families, at the same time professional relationships with colleagues were also strained by the addition of extra

patients. They described the tension between their commitment to providing patient-centred care and the limitations imposed by organizational constraints. A consistent message expressed by participants was that hallway health care not only overextends nurses it erodes relationships, trust, and morale. This theme is explored in two sub-themes: *They think we don't Care, but we do* and *Everyone's already drowning.*

They think we don't care, but we do

Participants described how hallway healthcare undermines their ability to provide care that aligns with their values and left them with guilt and for some a sense of failure: "*It made me feel moral distress because I couldn't give the patient care they deserve or that I am normally capable of"* (Participant 9). Some felt that patients and families misperceived them as uncaring or inattentive as the addition of extra patients in hallways added to nurses' workloads, which meant they had less time with patients. As patients in hallways were viewed as "stable" they were often seen last and less frequently than other patients.

> *"If I'm busy, they're probably one of the last patients I may choose to go see… If they can be in a hallway, they can't be that sick."* (Participant 6).

Patients' families interpreted less attention and privacy as lack of compassion: *"Patients don't know that I've been trying to get to them for an hour. All they see is that I haven't been there"* (Participant 7). Participants described patients directing anger toward them, unable to understand why their needs were unmet. As the visible "face" of a failing system, participants internalized blame and distress. This they believed had a detrimental effect on their relationships with patients and their families. Despite the perception of some patients and families, participants were clear—they care.

As described in the sub-theme *Unsafe by design: constrained in practice,* the hallways lacked privacy and compromised care. Participants shared their frustration at having to deliver care in an environment that felt inappropriate. It was believed that hallway placement negatively impacted the patient experience in terms of safety, privacy, and dignity. For instance, toileting patients in the hallways was seen as wrong. While the lack of privacy made participants reluctant to discuss serious and sensitive issues. The care provided didn't feel right: "*It just goes against what I believe… and it's hard to provide your best care when you're frustrated with the whole system"* (Participant 4). One key source of relational strain came from having to deliver news that a patient would be moved into the hallway. As described in the sub-theme: *We're not part of the conversation,* participants were not responsible for the decision but were still expected to deliver the news to patients and their families. This process was seen as destructive and damaging to the development and maintenance of therapeutic relationships and created a lack of trust. It was especially difficult when patients refused to be placed in the hallway, but participants had to enforce the decision or in cases where the patient was seen as vulnerable (i.e., frail and confused). Patients' and families' frustrations were sometimes directed at participants making them feel like the "bad guy". There were feelings of powerlessness and guilt over participants' inability to protect patients from hallway care even though the decision was outside their control. While some patients and families were understanding of the situation, consoling them, while being unable to change the situation, was described as morally exhausting.

> "*I feel like there's a lot of almost guilt associated with the fact they're stuck there and then you're trying to care for them. So, you're trying to make it up to them but there's not a whole lot more you can do"* (Participant 5).

Everyone's already drowning

Participants described how adding patients into hallways to already fast-paced and demanding surgical units took a cumulative toll on them physically and emotionally.

> "*It definitely increases stress levels because you're trying to figure out how to time manage for an extra patient. It's definitely exhausting. I had an extra patient for two days in a row... It was harder to try to time manage some aspects of my care, and I was honestly just waiting for every break or the minute I could try to sit down for a second to think, what have I actually done? What still needs to be done? Am I missing anything or my other patients?"* (Participant 1).

The stress of having additional patients in the hallways without extra resources and support went beyond individual nurses to impact relationships within their nursing teams and team morale. A common thread among participants responses was the overwhelming demands and sense of drowning, which left them scrambling to keep up.

> *"It takes a toll on everyone. Whether you're the nurse getting the patient or a nurse assigning the patient for the next shift. It definitely affects the whole vibe and morale of the unit"* (Participant 4).

Adding to the challenges, the assignment of patients in hallways often fell unevenly and did not always take into consideration other factors impacting participants' workloads such as patient assignments. This perceived unfairness sometimes created bitterness and conflict among participants and other staff members: *"It can lead to a lot of irritation between staff. It leads to a lot of us feeling disheartened, and we can take it out on each other"* (Participant 9).

Tensions were particularly heightened between staff during patient assignments as no one wanted an extra patient added to their already busy workload. Alongside these tensions, there

was also resignation as participants acknowledged that someone had to care for hallway patients. However, the chronic nature of hallway placements and routinely working beyond capacity had cumulative, long-lasting effects within their teams.

> *"I think that's actually been the more long-lasting effect for staff because the patients will come and go. But the staff is always there working. They say, 'ok, I had the extra patient last week and now I have an extra again, it's not fair.' So, I think that's actually been the lasting impact and there's definitely a sense of bitterness and frustration about it."* (Participant 1)

At the same time, participants repeatedly identified the critical importance of collegial support from the team as a buffer to keep them "afloat" amid the tensions and challenges: *"I know my colleagues are always going to help me. We're helping each other because we are a team"* (Participant 8). This solidarity was seen as essential, especially for newer nurses in this study, who felt less supported by management and more hesitant to speak up if their assignment was unfair. A recurring source of frustration for participants was the lack of meaningful leadership support within their units and organizations. Support often hinged on a manager's willingness and capacity to listen; while some managers occasionally responded and acknowledged participants concerns, others did not. Participants reported feeling worn down and discouraged by management, reporting that their concerns were often met with no real change, which eroded trust. As a result, participants felt disconnected from leadership.

> *"We're helping each other because we are a team. Our unit manager though, I feel like they're not doing their best as a manager to help us when they see us struggling"* (Participant 8)

Discussion

This study explored nurses' experiences of providing care in hallways within surgical inpatient units. The interconnected themes and sub-themes discussed highlight how hallway healthcare affects practice, ethics, relationships, and well-being. The placement of patients into hallways was not a temporary overflow strategy but had become normalized within practice, requiring nurses to adapt and manage the consequences of broader health system pressures with limited input into decision-making. These conditions created challenging work environments that limited the development of therapeutic relationships, strained teamwork, and contributed to moral and psychological distress, as well as physical strain. Participants consistently described the practice as demoralizing and misaligned with their professional values. These findings align with existing studies demonstrating that hallway placements compromise patient visibility, dignity, and safety, and increase the likelihood of missed care—particularly concerning for surgical patients who require close postoperative monitoring (Chang et al., 2016; Richardson et al., 2020; Rixe et al., 2018; Stiffler & Wilber et al., 2015).

While the literature predominantly focuses on the emergency department, consistent findings across Canadian and international studies show that hallway placement negatively affects patient experiences, including decreased satisfaction and increased feelings of exposure and neglect (Rasouli et al., 2019; Richardson et al., 2020; Villalona et al., 2020; MacIsaac & Peter, 2025). Research has also shown that prolonged overcrowding negatively affects care processes and nursing outcomes, contributing to burnout, misdiagnosis, and inappropriate treatments (Ahmed et al., 2024). Although these studies arise primarily from emergency care contexts, they help situate this practice in surgical inpatient units within broader conditions of sustained overcapacity, which can compromise communication, timeliness of care, and care

quality (Pentecost et al., 2020; Pines et al., 2007; Richards et al., 2011; Villalona et al., 2020; Richardson et al., 2020; MacIsaac & Peter, 2025).

Nurses' experience of hallway healthcare

A central finding from this study was the normalization of hallway healthcare within surgical inpatient units. Participants described it as "just part of the job," despite acknowledging the ethical, safety, and professional risks involved. What was once framed as temporary had become routine. As a result, accountability for managing unsafe conditions shifted away from organizational decision-making and onto nurses. This was particularly notable for internationally educated nurses, who expressed shock that these practices occurred within the Canadian healthcare system. Participants' accounts highlight a disconnect between expectations and the realities of frontline nursing work, reflecting broader concerns about deteriorating inpatient conditions. Over time, participants described adapting to this practice even when it conflicted with their professional and personal values. These findings raise important questions about how continued exposure to such conditions may shape nurses' professional identity, resilience, and long-term expectations of practice.

Structural and organizational pressures

Participants described significant emotional strain related to being responsible for patient care while lacking control over decisions about hallway placements. Nurses were held accountable for patients without any say in staffing, patient flow, or physical space. Lack of support from leadership and poor communication were common concerns. Hallway placements were rarely discussed before being implemented, undermining trust in leadership. Research on effective leadership emphasizes transparency and consistency in communication as essential for trust, helping nurse leaders motivate teams, promote patient-centred care, and reduce burnout

(Kämäräinen et al., 2025; McMillan, 2024; Stillman et al., 2024). The lack of communication and support placed nurses in situations where meeting standards of care felt unattainable. This misalignment is strongly associated with moral distress, burnout, and intentions to leave the profession (Lamiani et al., 2017; Lessi et al., 2024; Mandrell et al., 2023).

Hallway placement was perceived as particularly concerning in surgical settings, where patients often require close monitoring, specialized equipment, and strict infection prevention measures to prevent complications. Participants described caring for patients with wounds and infusion pumps in environments that lacked adequate space and privacy and compromised sterility. The inability to meet expected care standards contributed to feelings of guilt, frustration, and helplessness. Recent research indicates that moral distress is intensified when nurses practice within healthcare systems experiencing sustained pressures, including staffing shortages, overcrowding, and resource limitations (Mandrell et al., 2023).

Recent national initiatives in Canada acknowledge the need to address these pressures through reform. Health Canada's *Nursing Retention Toolkit: Improving the Working Lives of Nurses in Canada* (2024) outlines evidence-informed strategies targeting workload, leadership practices, psychological safety, and physical work environments. This initiative is intended to support employers and organizations in improving nurses' working conditions. In a recent report, *Sustaining Nursing in Canada* (2024), the Canadian Federation of Nurses Unions (CFNU) focuses on retention and support of current nurses, return of nurses to the public sector, and recruitment. The CFNU (2024) outlines a multi-step, multi-faceted set of targeted actions aimed at addressing the current healthcare crisis. In addition, provincial nursing unions and professional organizations continue to advocate for enforceable staffing standards, safer workloads, and infrastructure investment. Both British Columbia and Nova Scotia have been successful in

developing mandated nurse-to-patient ratios, which may help enhance quality of care and support nurse well-being (McTavish & Blain, 2024).

Relational, ethical, and professional consequences

Hallway healthcare had substantial implications for the relational dimensions of nursing practice. Limited space and lack of privacy constrained nurses' ability to communicate effectively with patients and families, conduct thorough assessments, and preserve dignity during care. Therapeutic relationships were also frequently disrupted. Nursing relies heavily on the ability to build and sustain therapeutic and collaborative relationships. Studies indicate that when nurses are unable to engage with patients and develop rapport, they report distress and concern about the quality of care (Foss & Krogstad, 2000; Pines et al., 2007; Pentecost et al., 2020; Richardson et al., 2020; Villalona et al., 2020).

Team relationships were similarly affected. Patients receiving hallway healthcare were often added to nurses' assignments without adjustments to workload or staffing, contributing to fatigue and tension within nursing teams. Peer support and teamwork have been shown to foster professional identity and resilience in stressful environments (Cunningham & Geyer, 2023; Watson et al., 2024). However, while they may provide temporary relief and a sense of solidarity, they cannot mitigate ongoing organizational challenges related to overcrowding. These findings illustrate how these conditions undermine nurses' physical, psychological, and professional safety, thereby perpetuating moral distress.

Recommendations

Addressing the impact of hallway healthcare requires coordinated action across system, organizational, and individual levels. Without multi-level intervention, hallway healthcare risks remaining normalized despite its harms. These findings have important implications for nursing

practice and patient care. Emerging evidence-based recommendations, such as the *Nursing Retention Toolkit* (Health Canada, 2024) and *Sustaining Nursing in Canada* (CFNU, 2024), could be used by employers and institutions. Continued research is needed to further explore these issues and identify effective, system-level strategies that can strengthen work environments and support nurses. Research on infection rates among patients placed in hallways is warranted, as these patients may have higher exposure to environmental pathogens. Additionally, further investigation into complications associated with this setting is needed. Investigating nurse-led policy advocacy or leadership in overcapacity planning may also identify pathways to strengthen nurses' involvement in decision-making.

Limitations

There are several limitations to acknowledge. First, the findings are limited to the perspectives of surgical nurses practicing in Ontario, Canada, where healthcare delivery is shaped by provincial policy and funding structures. This may limit the transferability of the findings beyond this context. In addition, this study focused on surgical inpatient settings, the findings may not reflect the experiences of nurses working in other clinical areas. Surgical units are characterized by rapid workflow, high turnover, patient acuity and complexity, and variability related to planned surgeries and emergency demands. Further research in other inpatient settings is warranted. Finally, the sample size was small (nine participants). While appropriate for qualitative inquiry and sufficient to generate rich, in-depth accounts, the sample may not reflect the full range of experiences among surgical nurses.

Conclusion

This study explored nurses' experiences of providing care in hallway environments within the surgical inpatient setting. Their accounts reveal that hallway healthcare is not simply an issue

of space but a systemic problem that compromises patients' safety and dignity, affects the quality of care, and negatively impacts nurses' well-being. By amplifying the voices of nurses and exposing the consequences of hallway healthcare, this research highlights the need for systemic change to move away from hallway healthcare and instead create practice environments where nurses are respected and valued.

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Chapter 5 Discussion

5.1 Introduction

This chapter discusses the findings of this study, which explored surgical nurses' experiences of providing care in hallways. The discussion focuses on three fundamental areas: nurses' experiences of hallway healthcare, structural and organizational pressures, and the relational, ethical, and professional consequences of this practice. The findings are examined in relation to existing literature and interpreted through the RNAO *Conceptual Model for Healthy Work Environments* (2007), which serves as the guiding framework for the analysis. The HWE Model is used to illustrate how macro-, meso-, and micro-level factors intersect to shape nurses' day-to-day realities. The discussion also draws on recent Canadian policy initiatives aimed at improving nurses' working conditions and retention, as well as relevant best practice guidelines (e.g., Health Canada, 2024; RNAO, 2007). As this is a master's in nursing thesis, it is also important to examine the Advanced Practice Nurse (APN) role in fostering healthier, more sustainable work environments through leadership, advocacy, and mentorship. The chapter concludes by addressing the study's limitations and offering a final reflection on the implications.

5.2 Nurses' experiences of hallway healthcare

Participants' accounts revealed how hallway healthcare has become an accepted yet deeply troubling aspect of their nursing practice. What was once intended as a temporary measure for overflow has, over time and through the COVID-19 pandemic, evolved into a normalized practice. Viewed through the lens of the HWE Model (RNAO, 2007), hallway healthcare undermines every component of a work environment required for safe, ethical, and high-quality nursing practice. Participants characterized hallway care as demoralizing, unsafe, and misaligned with their professional values. This normalization was described not as true

acceptance, but rather as resignation to the realities of the current healthcare system. Several participants reflected that hallway healthcare is considered "part of the job," yet it feels wrong; this disconnect wears them down physically, emotionally, and morally, while placing patients at risk. Existing research echoes these concerns, demonstrating that hallway placements compromise patient visibility, dignity, and safety, and increase the likelihood of missed care (Chang et al., 2016; Richardson et al., 2020; Rixe et al., 2018; Stiffler & Wilber, 2015). In the current study, participants expressed particular concern for surgical patients, who require close postoperative monitoring and are at increased risk for complications such as wound infections. International evidence further links prolonged overcrowding to poorer nursing care outcomes, including nurse burnout, patient misdiagnosis, and inappropriate treatments (Ahmed et al., 2024). Despite these clear risks, participants reported being expected to "make it work," which shifted accountability away from administration and management and onto nurses, who bore responsibility without having decision-making authority. Being held accountable by patients and families for placement decisions beyond their control weighed heavily on participants, creating frustration that unsafe practices were treated as acceptable, as well as guilt for being unable to provide an adequate level of care. The chronic emotional toll of these expectations and compromises contributed to physical and emotional exhaustion, as well as moral distress. This finding is consistent with existing literature. There is evidence to suggest that in healthcare systems "under pressure," nurses' moral distress is intensified (Mandrell et al., 2023). The cumulative effects of moral distress have been linked to reduced job satisfaction and increased nurse turnover (Aljabery et al., 2024; Kim et al., 2023).

The emotional and moral distress experienced by participants was further compounded by the physical constraints of working in chaotic and unsafe environments. The breakdown of

physical safety—an essential component of a healthy work environment—placed participants at risk for both physical and psychological harm. Participants reported feeling compelled to continue working under these conditions, as repeated attempts to raise concerns had little to no impact. This contributed to feelings of powerlessness and being unheard. Combined with a sense of being "responsible without power," participants described feeling helpless and less able to advocate for their patients. Over time, this eroded their confidence in upholding safe and ethical standards and undermined their sense of professional integrity. Such conditions can silence nurses' voices and limit their ability to advocate for themselves and those in their care. Zou et al. (2025) describe this phenomenon as *acquiescent silence*, which occurs when nurses refrain from speaking up due to the belief that doing so will not lead to change, or because past experiences of not being heard have rendered such efforts futile. Poor communication and limited accountability are additional factors that compromise patient safety (Logorno et al., 2023). Collectively, these findings illustrate how systemic underfunding, chronic overcapacity, and organizational policies for managing bed demand directly impact nurses and their practice.

5.3 Structural and organizational pressures

Participants linked the day-to-day realities of hallway healthcare to broader structural and organizational failures, reflecting the HWE Model (RNAO, 2007) and the intersections across its various levels. Macro-level system pressures, policy decisions, and funding constraints shaped meso-level strategies and organizational conditions, such that organizational cultures normalized hallway healthcare as a bed management strategy. Pressures at the macro- and meso-levels directly affected nurses at the micro-level, who were left balancing ethical responsibilities with institutional policies. While participants described varying nurse-to-patient ratios across their institutions, it was evident that hallway healthcare further altered these ratios, increasing nurses'

workloads and creating unsafe environments in which to provide patient care. Evidence from a recent study suggests that a mandated 1:4 nurse-to-patient ratio promotes safer and more effective care (Havaei et al., 2025). However, without mandated nurse-to-patient ratios, nurses and patients remain unprotected. Despite the risks associated with higher nurse-to-patient ratios, British Columbia and Nova Scotia remain the only two provinces with legislated ratios aimed at limiting these increases (BCNU, 2024; NSNU, 2024).

A lack of leadership support and poor communication were common concerns in the current study. Hallway placements were rarely discussed before being implemented, which undermined trust in leadership. Research on effective leadership emphasizes transparency and consistency in communication as essential to building trust, helping nurse leaders motivate their teams, promote patient-centred care, and reduce burnout (Kamarainen et al., 2025; McMillan, 2024; Stillman et al., 2024). In the absence of formal guidance on hallway healthcare across most hospitals where participants worked, there were inconsistencies in how it was implemented. According to the RNAO *Developing and Sustaining Nursing Leadership* BPG (2013), timely, open communication and participative decision-making are vital to creating a culture of trust and teamwork. Evidence also suggests that when nurses feel respected and trusted by leadership, job satisfaction and quality of care are higher (den Breejen-de et al., 2021; Huang et al., 2025; McMillan, 2025; RNAO, 2013).

These findings point to the need for meso-level changes to strengthen nurses' psychological safety, rebuild trust, promote open communication, and restore a sense of professional identity. Nursing leadership should model open dialogue and amplify nurses' voices (Noth-Matchett & Stoerger, 2025). Strategies include promoting organizational values such as

communication and constructive feedback between upper and lower levels, fostering a culture of trust and active listening, and establishing clear job expectations (Zou et al., 2025). Teamwork and support within participants' units helped offset some of the challenges associated with managing patient care amid hallway placements. Support from peers has been shown to foster professional identity and resilience in stressful environments (Cunningham & Geyer, 2023; Watson et al., 2024). While teamwork offers temporary relief and a sense of solidarity, it does not address broader macro-level issues. As such, support from coworkers, while valuable, cannot compensate for chronic structural issues at the macro-level or for organizational "solutions" to overcrowding. Overall, these findings illustrate how systemic and organizational issues undermine nurses' physical, psychological, and professional safety, thereby perpetuating moral distress.

5.4 Union implications

Building on the previous discussion of macro-, meso-, and micro-level influences, participants' accounts reinforce that hallway healthcare is not simply an issue of individual nursing practice, but a reflection of broader structural and organizational conditions. While participants described adapting their practice in response to ongoing constraints, their experiences highlight how responsibility has shifted away from systems and organizations and onto individual nurses. As discussed earlier, the normalization of hallway healthcare reflects not only resource strain, but also a broader shift in what is considered acceptable within healthcare environments. In this context, nurses are left to absorb and navigate these conditions, echoing concerns in the literature regarding the realities of nursing practice and decisions to leave the profession (CFNU, 2022; Health Canada, 2024).

These findings underscore the need to re-centre responsibility at the organizational and system levels. Healthcare organizations play a critical role in shaping the conditions under which care is delivered, including decisions related to capacity, staffing, and the use of space. This aligns with existing evidence demonstrating that system-level factors, such as staffing models, organizational culture, and workload, are key determinants of nurses' well-being (Aiken et al., 2025; Health Canada, 2024; Lamiani et al., 2017; Lessi et al., 2025).

Within this context, unions and professional organizations have important roles in addressing the issues identified. In Ontario, the Ontario Nurses' Association (ONA) and the Registered Nurses' Association of Ontario (RNAO) have drawn attention to unsafe staffing, workload pressures, and the impact of hallway healthcare (ONA, 2007, 2024; RNAO, 2013, 2019). While these efforts have primarily focused on staffing ratios and workload, the findings of this study suggest that the physical and structural conditions of care require attention. Unions are uniquely positioned to advocate for enforceable standards that address not only staffing levels, but also the environments in which care is delivered. Strengthening advocacy for safe staffing legislation, limits on the use of hallway spaces, and greater organizational accountability remains essential.

At the same time, participants did not explicitly identify unions as a source of support or intervention, despite their central role in advocacy. This absence is notable, particularly given that nurses contribute union dues to support political action, policy change, and collective bargaining. The lack of reference to unions could reflect the degree of resignation evident in the findings. As discussed earlier, hallway healthcare has become so normalized that reporting unsafe conditions may not be readily considered likely to result in meaningful change. This

raises an important area for further exploration, including how nurses perceive the role and impact of unions and how organizations might better support their members.

5.5 Relational, ethical, and professional consequences

Hallway healthcare not only reshaped participants' daily routines, but also disrupted their relationships with patients, families, and colleagues. The structural realities of hallway placements disrupted key features of a healthy work environment, including privacy, confidentiality, and the ability to provide safe, dignified care (Richardson et al., 2020; Richards et al., 2014; Stiffler & Wilber, 2015; Villalona et al., 2020). These challenges are consistent with the expectations outlined in the RNAO HWE Model (2007), which emphasizes the organizational and interpersonal conditions required for safe, ethical, and high-quality nursing care. Without appropriate physical environments, studies show that nurses are unable to maintain confidentiality and effectively engage in therapeutic relationships with patients and families (Lopez et al., 2022; Villalona et al., 2020).

As a profession, nursing is inherently relational, relying on the ability to build and sustain therapeutic relationships. Yet, participants described a disconnect between their professional values and the care environment. When nurses are unable to connect with patients, both care and communication are affected (Foss & Krogstad, 2000; Pentecost et al., 2020; Pines et al., 2007; Richards et al., 2011; Richardson et al., 2020; Villalona et al., 2020; MacIsaac & Peter, 2025). According to the professional component of the HWE Model (RNAO, 2007), when core features such as resilience, self-confidence, and commitment to the organization are undermined, the result can be poor communication, potential errors, and erosion of professional identity. Participants noted reduced interaction with patients placed in hallways compared to others in

their assignment. Some viewed this as a failure to uphold expected standards of care, which challenged their professional identity and contributed to moral distress.

Team relationships were also strained. Hallway placements increased workload and redistributed responsibilities, with some participants describing assignments as unfair. The RNAO *Intra-professional Collaborative Practice Among Nurses* BPG (2016) emphasizes that teamwork is strengthened by building supportive teams, fostering collegiality, improving collaboration among new graduates, managers, registered practical nurses, and registered nurses, and valuing respectful communication between nurses. While peer support provided some relief, it was insufficient to offset the sustained demands created by hallway healthcare (Baek et al., 2023; Bakht et al., 2024).

At the micro-level, environmental strain can evolve into moral and psychological harm. Participants expressed that their ongoing inability to provide safe, person-centred care conflicted with their core values, leading to feelings of guilt, helplessness, and a fractured sense of professional identity. This finding aligns with existing literature linking poor work environments to emotional exhaustion and moral distress, which, over time, are associated with nurses' intentions to leave the profession (Lamiani et al., 2017; Lessi et al., 2024; Mandrell et al., 2023).

Addressing these relational, ethical, and professional consequences requires more than individual resilience or coping strategies. Meaningful change, guided by the HWE Model (RNAO, 2007), requires macro-, meso-, and micro-level strategies, including system-level investment in capacity and staffing, mandated nurse-to-patient ratios, organizational accountability, collaborative leadership, and alternatives to hallway healthcare. Without such changes, outcomes such as moral distress, burnout, and professional disillusionment are likely to persist (Backstrom et al., 2024; Enea et al., 2024; Lyu et al., 2024).

In summary, the findings and literature discussed reveal that hallway healthcare is not only a source of physical and psychological strain for nurses, but also a threat to professional integrity. The implications of these findings extend across the system levels of the HWE Model (RNAO, 2007) used in this study. The discussion now turns to more recent evidence and models that address these issues.

5.6 Implications for Advanced Practice Nurses

Building on the preceding discussion, the findings of this study highlight that hallway healthcare reflects broader structural, cultural, and interpersonal conditions shaping nurses' work environments. Participants' accounts reveal that these challenges extend beyond individual nursing practice and require responses across multiple levels of the system. In this context, Advanced Practice Nurses (APNs), an umbrella term that includes registered nurses and nurse practitioners with graduate-level education, clinical knowledge, and expertise (CNA, 2019), are well positioned to address these conditions through their roles in clinical practice, leadership, education, and policy.

APNs play an important role in bridging gaps between frontline experiences and organizational decision-making. At the micro-level, they can support nurses working in constrained environments through structured mentorship, reflective practice, and facilitated debriefings that address ethical tensions and clinical decision-making. These strategies are particularly relevant in the context of hallway healthcare, where nurses experience ongoing moral distress and challenges in maintaining professional standards. At the meso-level, APNs can strengthen communication and collaboration by promoting teamwork, supporting interprofessional relationships, and contributing to health and safety initiatives. At the macro-

level, APNs can advocate for system-level changes, including safe staffing policies, improved capacity planning, and limits on the use of hallway healthcare.

These roles align with the RNAO Healthy Work Environment (HWE) Model (2007), which emphasizes coordinated action across macro-, meso-, and micro-levels. Relevant RNAO Best Practice Guidelines further support these strategies, including *Healthy Work Environments* (2010), *Professionalism in Nursing* (RNAO, 2007), *Developing and Sustaining Safe, Effective Staffing and Workload Practices* (RNAO, 2017), and *Developing and Sustaining Nursing Leadership* (RNAO, 2013).

Within inpatient surgical settings, these roles take on additional significance. Participants' accounts highlight that hallway healthcare in surgical units is associated with heightened risks due to the need for timely monitoring, postoperative assessment, and infection control. In this context, APNs can support clinical decision-making, coordinate care, and address environmental barriers that directly impact patient outcomes (Assolari et al., 2023). Their role extends beyond direct patient care to include leadership and quality improvement initiatives that respond to the specific demands of surgical care environments. They can also contribute to the development of care pathways that account for capacity limitations while maintaining patient safety and quality of care. This includes identifying risks associated with alternate care spaces and supporting the implementation of practices that prioritize both clinical and relational aspects of care. In their educational and leadership roles, APNs can support critical reflection and guide nurses in navigating constrained environments without normalizing unsafe practices.

The Canadian literature reinforces the importance of APN roles in addressing these challenges. The *Nursing Retention Toolkit* (Health Canada, 2024) highlights APNs as leaders and consultants who can create formal channels for incorporating frontline nurses' perspectives into

decision-making, an issue identified in this study. Similarly, the Canadian Association of Schools of Nursing (CASN, 2025) emphasizes that APNs contribute to reshaping healthcare systems by influencing quality, equity, and organizational culture. These roles extend beyond individual clinical encounters to include policy development and system-level leadership, which are directly relevant to the structural conditions underpinning hallway healthcare.

This positioning is also supported internationally. The International Council of Nurses (ICN, 2020) identifies APNs as contributors to system transformation through expert clinical judgment, leadership, and evidence-based practice. The ICN emphasizes that APNs improve care environments, enhance interprofessional collaboration, and address barriers to safe practice. Central to this role is the need for clear understanding and organizational support for APN roles. When these roles are well defined and integrated into practice, APNs are better able to influence practice outcomes, system performance, and workforce conditions (ICN, 2020).

However, APNs capacity to address these challenges is limited by the small proportion of nurses in these roles. Data from the College of Nurses of Ontario (CNO, 2025) indicate that only 0.3% of nurses are employed as clinical nurse specialists and an additional 0.3% in other APN roles. This limited presence constrains the visibility and impact of APNs, particularly within surgical settings, and underscores why responsibility for addressing hallway healthcare cannot rest with APNs alone. It also highlights the need for greater investment in APN roles so that their leadership, clinical expertise, and systems-level contributions can be more fully realized. Further, it emphasizes the need for collective engagement across the profession, with nurses working in partnership with APNs, educators, leaders, and other key stakeholders to address the structural conditions shaping care delivery

5.7 Building on established and emerging evidence

Recent national reports suggest that many of the recommendations emerging from this study are already being advanced by nurses across Canada. The CASN Vision 2028 and Health Canada's *Nursing Retention Toolkit* draw attention to structural and cultural factors that influence nurse retention, workload, and workplace climate. These areas closely reflect participants' experiences of hallway healthcare. Together, these reports demonstrate that the conditions nurses are calling for are both recognized and actionable within current policy directions.

Health Canada's *Nursing Retention Toolkit* (2024) outlines strategies informed by clinical expertise, evidence-based practice, and the lived experiences of frontline nurses. The toolkit focuses on eight core themes that influence retention and provides employers with practical tools to strengthen workplace culture, support psychological safety, and enhance staffing stability (Health Canada, 2024). Each theme identifies the intended population, anticipated outcomes, and responsibilities of key stakeholders, offering a clear and sustainable pathway for translating recommendations into action. Importantly, the toolkit speaks directly to several of the levels highlighted in this study's findings. Its focus on communication, shared accountability, and meaningful engagement closely aligns with the concerns raised by participants. Its emphasis on retention as both a structural and relational priority further demonstrates the need for a coordinated, system-level approach.

The CASN Vision 2028 outlines a national direction for nursing education that seeks to reimagine and transform academic and clinical learning (CASN, 2025). Central to this vision is strengthening the connection between education, practice, and the broader healthcare system. These same priorities are reflected in participants' emphasis on upholding nursing values,

enabling safe and ethical practice, and preserving a sense of professional identity within the work environment. However, participants' accounts suggest that this connection is not always realized. Their experiences highlight a disconnect between what is taught and what is possible in practice. In constrained settings, nurses are expected to meet professional and ethical standards without being provided with the conditions necessary to do so. In this way, supporting nurses to practise safely and ethically is not only a professional expectation, but also a structural responsibility that must be sustained through education, mentorship, and leadership. Without this alignment, the gap between education and practice persists, leaving nurses to navigate tensions between what they know should be done and what they are realistically able to do.

5.8 Broader implications

The experiences described in this study point to changes that extend beyond the individual level to organizational and system levels. Participants consistently emphasized that hallway healthcare is not simply a unit-level concern, but a structural issue tied to capacity decisions, staffing models, and communication pathways. These findings reinforce the need for coordinated action across all levels.

At the macro-level, the implications of hallway healthcare extend to decisions related to system capacity, resource allocation, and staffing. Policy advocacy is needed to promote equitable workloads and system capacity in ways that reduce reliance on hallway spaces. The RNAO *Developing and Sustaining Effective Staffing and Workload Practices* BPG (RNAO, 2017) emphasizes the importance of political action and advocacy for funding and policy support that enable safe staffing and workforce infrastructure. Similarly, the Health Canada *Nursing Retention Toolkit* (2024) highlights that nurse retention is closely linked to capacity planning, policy decisions, and long-term investment. Ensuring that nursing perspectives are included in

policymaking and capacity planning may help reduce top-down approaches and hierarchical pressures (Health Canada, 2024).

At the meso-level, the RNAO *Healthy Work Environment* BPG (2007) calls for fostering cultures that value psychological safety, open communication, and collaborative practice. In the context of hallway healthcare, this includes improving communication among teams, promoting shared accountability, and supporting staff engagement in decision-making. Strengthening communication structures, leadership visibility, and staff involvement, also emphasized in the Health Canada *Nursing Retention Toolkit* (2024), may help reduce the disconnect between nurses lived experiences and organizational values. In surgical inpatient settings, where timely monitoring, assessment, and infection control are critical, participants linked the emotional and ethical burden of hallway healthcare to the absence of cohesive leadership practices. Addressing these leadership gaps may strengthen trust, shared decision-making, and teamwork.

At the micro-level, mentorship, coaching, and emotional support are essential for nurses working under sustained pressure. The RNAO *Developing and Sustaining Nursing Leadership* BPG (2013) emphasizes that supportive leadership and mentorship are central to fostering nurse well-being and professional identity. In the context of hallway healthcare, this includes creating space for reflection, validating ethical challenges, and modelling supportive leadership. By helping nurses navigate moral distress and value conflicts, leaders and mentors can strengthen professional identity and resilience. Mentorship has also been associated with improved nurse retention (RNAO, 2013). These approaches provide nurses with opportunities to discuss workload pressures and ethical dilemmas that arise when hallway healthcare prevents them from meeting professional standards. Establishing formal or informal support networks and using strategies such as structured debriefing may further support nurses in managing moral distress,

particularly in surgical settings where rapid changes in patient conditions limit opportunities for reflection.

5.9 Research implications

The findings have important implications for nurses, nursing practice, and patient care. Hallway healthcare contributes to physical and psychological strain, as well as moral distress, all of which can compromise nurse well-being, teamwork, and quality of care (RNAO, 2021; Li et al., 2024). Continued research is therefore needed to better understand these effects and to identify system-level strategies that strengthen work environments and support nurses. Future research could also examine how the normalization of unsafe practices, created by hallway healthcare, shapes nurse behaviour, morale, and system expectations over time, including how these patterns vary across settings and healthcare systems. Further, investigating nurse-led policy advocacy or leadership in overcapacity planning may identify ways to strengthen nurses' voices in decision-making processes. Specific to the inpatient surgical context, many participants emphasized that postoperative care in hallway spaces was unacceptable. Maintaining cleanliness and reducing exposure to pathogens is challenging in the busy and exposed hallway environment. Research examining infection rates, complications, and other adverse outcomes among patients placed in hallways is therefore warranted.

5.10 Limitations

This study has several limitations that are acknowledged. First, the findings are limited to perspectives of surgical nurses practicing in Ontario. Health care delivery is influenced by provincial policy, funding structures, and organizational culture. This means that experiences may differ across other regions of Canada and even internationally. Future research could broaden this scope to capture how hallway care is understood and managed in other inpatient

units' areas and cultures. The chosen context for this study was the inpatient surgical unit. While focus provided insight into how hallway healthcare intersects with surgical workflow, patient acuity, and discharge pressures, it may not fully reflect those of nurses working in other settings. Other units and patient populations may have resource demands and additional ethical complexities that warrant further exploration. While the participants provided rich, detailed accounts that reveal several patterns, the findings are not transferable to all nurses.

The HWE conceptual model (RNAO, 2007) provided a broad framework for the study situating participants' experiences within macro-, meso-, and micro-level influences. A limitation of the model is that it predates several contemporary inpatient realities shaping nurses' work, including COVID-19 and post-pandemic conditions that participants linked to the normalization of hallway healthcare. There is also a lack of specificity as it is a high-level model. Despite these limitations, in this qualitative study the model guided but did not constrain data collection or interpretation. For example, participants' emphasis on constraints to their practice and the resulting moral distress, while not a discrete component of the model, was interpreted through the model's focus on well-being and safe practice conditions. Model development could integrate evidence to reflect these realities.

5.11 Conclusion

This study explored nurses' experiences of providing care in hallway environments within the surgical context. By listening to their voices, it illuminated how hallway care affects nursing practice, patient safety, and the ethical integrity of care. Using Thorne's interpretive description (2016), the findings reveal that hallway care is not merely a result of limited space but a systemic issue that reshapes practice, compromises safety and dignity, and erodes the conditions needed for ethical, relational care. By centring nurses' experiences, this study

challenges the normalization of hallway care and exposes its ethical and professional consequences. Hallway healthcare is neither sustainable nor acceptable. The findings add support to the growing literature on the adverse impact of hallway healthcare and the need for healthcare systems and organizations to move beyond it by investing in capacity, workforce, and environments that enable safe, ethical, and dignified practice. Amplifying nurses' voices makes clear the urgency of creating environments that respect and support those who provide care.

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Appendices

Appendix A: Literature Search Strategy

Table 1. Literature Review Inclusion and Exclusion Criteria

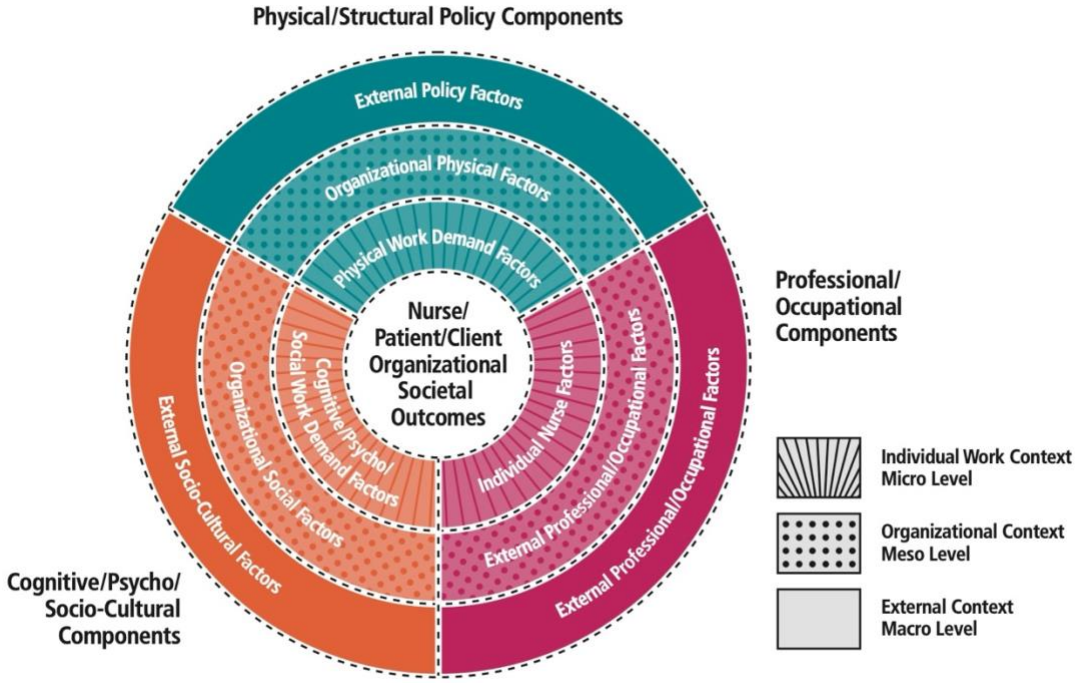
Inclusion Criteria	Exclusion Criteria
• English language • Published 2005 and later • Peer reviewed • Nurses • Hospital nursing • Inpatient units	• Research focusing only on hallway policy

Table 2. Literature Review Search Strategy

Source	Search strategy	Number of documents identified/those meeting the inclusion criteria
CINAHL electronic database search	Searching Ti(title) and Ab(abstract) Limited to English language, dated 2005-present *corridor* OR *hallway* AND *patient** OR *care* OR *healthcare* OR *medicine* OR *nurs** OR *bed** OR *surgery**	32/4
Medline/PubMed electronic database search	Searching Ti and Ab Limited to English language, dated 2005-present *corridor* OR *hallway* AND *patient** OR *care* OR *healthcare* OR *medicine* OR *nurs** OR *bed** OR *surgery**	424/13
World Wide Web	General searches using *hallway nursing*, *corridor nursing*, *nursing implications, hallway medicine*	35/8
Backward citation searching of reference lists	The reference list of documents included in the literature review (duplicates removed)	16/7

Appendix B: Conceptual Model

Figure 1: Registered Nurses Association of Ontario Healthy Work Environments for Nurses: Conceptual Model



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Appendix C: Recruitment Leaflet

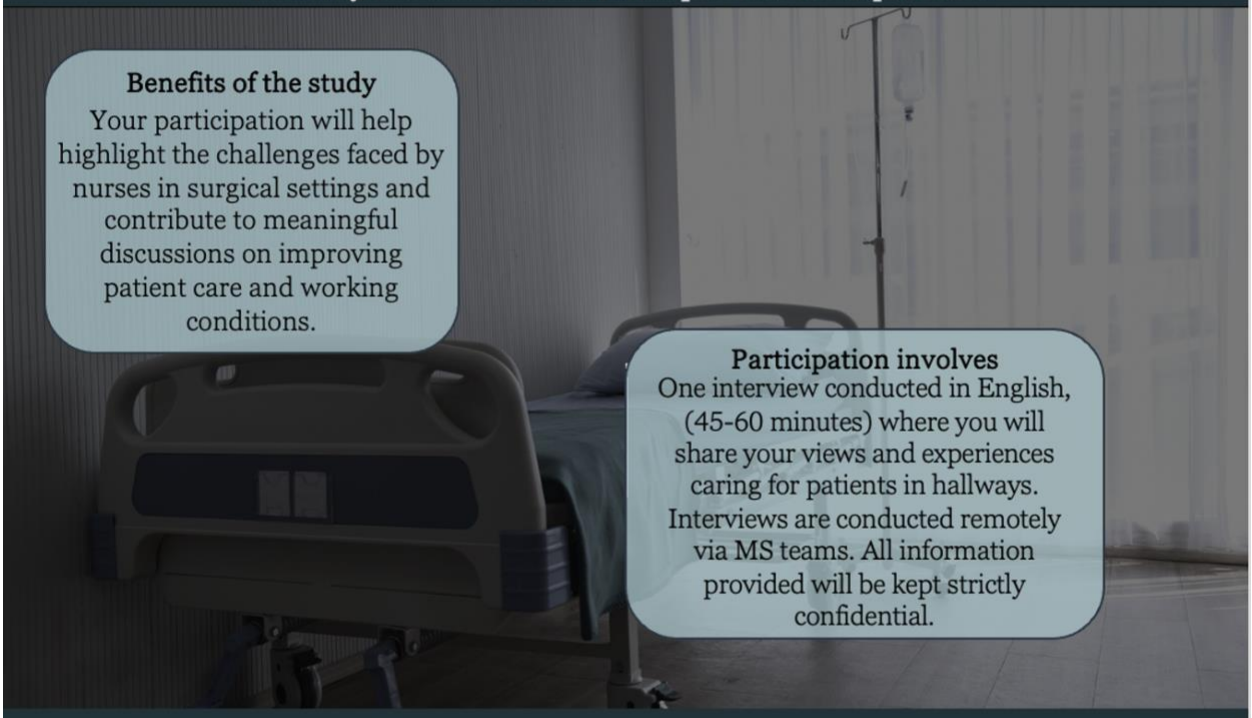
uOttawa

Study: Surgical nurses' experience of caring for patients admitted into hallways

Are you an RN or RPN working full-time, part-time, or casually in Ontario, with experience in inpatient surgical care?

Have you cared for patients admitted into hospital hallways?

We are seeking your insights to better understand surgical nurses' perspectives on hallway healthcare and its impact on their practice.



Benefits of the study
Your participation will help highlight the challenges faced by nurses in surgical settings and contribute to meaningful discussions on improving patient care and working conditions.

Participation involves
One interview conducted in English, (45-60 minutes) where you will share your views and experiences caring for patients in hallways. Interviews are conducted remotely via MS teams. All information provided will be kept strictly confidential.

Who we are?

I am Zoe Ruddy (RN, BScN), a surgical nurse conducting this study as part of my master's in nursing thesis in the School of Nursing at the University of Ottawa, Ontario, Canada. My thesis advisor is Associate Professor Dr. Christine McPherson RN, PhD.

If you are interested, please contact me: [redacted]

The ethical components of this study have been approved by the Research Ethics Board. For questions about the ethical conduct of the study, contact the Protocol Officer for Ethics in Research, University of Ottawa, ethics@uottawa.ca

Appendix D: Informed Consent

Study title: Surgical Nurses' Experiences of Hallway Healthcare

Researcher: Zoe Ruddy RN, MScN student
Thesis supervisor: Christine J. McPherson, RN, PhD, Associate Professor
School of Nursing, Faculty of Health Sciences,
University of Ottawa

Invitation to Participate: I am invited to participate in the above-mentioned research study conducted by Zoe Ruddy as part of her master's in nursing thesis and supervised by Associate Professor Christine McPherson.

Purpose of the Study: The purpose of the study is to gain an understanding of surgical nurses' experiences when caring for patients who are admitted into inpatient unit hallways. Its purpose is to inform future policy or procedure change to improve nursing practice.

Participation: My participation will consist of one individual interview with the researcher (Zoe Ruddy) lasting approximately 45-60 minutes. The interview will be conducted, and audio recorded using Microsoft Teams with a secure password protected account. I understand that the video camera features for both interviewer and interviewee will be turned off at the start of the interview as only audio recordings will be used for data. During the interview demographic information will be collected for the purpose of describing the sample who took part.

Risks: My participation in this study will mean that I will volunteer personal information and discuss my experiences caring for hallway patients. I do not anticipate experiencing discomfort from discussing my experiences regarding hallway healthcare. However, the researchers have assured me that every effort will be made to minimize any potential discomfort. I understand that I may refuse to answer any question and can withdraw from the study at any time.

Benefits: My participation in this study will provide insight into surgical nurses' experiences with hallway healthcare and its implications. These insights will inform policy and procedures to better support nurses in their practice.

Confidentiality and Privacy: All data is electronic and will be stored on Christine McPherson and Zoe Ruddy's University of Ottawa Microsoft OneDrive account. The accounts are password protected and require two-factor authentication to access. All files will be password protected. The researcher (Zoe Ruddy) and her thesis supervisor (Christine McPherson) will be the only individuals with access to transcripts, researchers' notes, and consent forms.

The information I share will remain strictly confidential and my identity protected. All data will be de-identified. This means that all identifying information will be removed, including names and places, and any unique situations that I discuss that could identify me. I understand that the

researchers may use direct quotes from the interviews in publications and presentations, but pseudonyms will be used and identifying information will be removed. The information I provide will be used only for the purposes of the study as outlined in this consent form.

Conservation of Data: In line with the Research Ethics Board, the data will be retained for five years before being deleted. Following the student's departure from the university, all data will be transferred and stored electronically on Christine McPherson's Ottawa Microsoft OneDrive account. The computer and files will remain password protected, and data encrypted.

Compensation: There will be no compensation for participating in this study.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without any negative consequences. If I choose to withdraw, my data will be destroyed and not used in the study.

If I have any questions about the study, I can contact Zoe Ruddy. If I have any questions regarding the ethical conduct of this study, I can contact the Office of Research Ethics and Integrity by email (ethics@uottawa.ca) or telephone (613-562-5800 ext. 5387). It is recommended that I save a copy of this consent form for my records.

Acceptance: I can indicate my consent to participate in the study either by providing written or verbal consent. To provide written consent, I will sign the consent form and return it via email to Zoe Ruddy. Alternatively, I can provide verbal consent after reviewing the consent form with Zoe Ruddy prior to my interview.

Participant's name: _____

Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix E: Interview Guide

Participant Information

Demographic information
- Age
- Gender

Nursing information
- Nursing designation (RPN, RN, or NP)
- Length of time working as a nurse
- Length of time working on the unit where hallway healthcare occurred
- Role on the unit where hallway healthcare occurred

Contextual information
- Surgical specialty
- Information about the organization and unit where hallway healthcare occurred, including:
    - geographic location
    - size of the unit
    - size of the hospital
    - patient population cared for on the unit
    - staffing ratios

Broad Areas of Exploration, Interview Questions, and Prompts

Can you tell me about your experience with hallway healthcare?
Prompts:
- *Can you tell me more about that?*
- *Can you give me an example?*
- *How did that make you feel?*

What typically happens when a patient is assigned to a hallway bed?
Prompts:
- *Are there any policies or operating procedures?*
- *What is the basis for the decision?*
- *Who makes the decision?*
- *What input, if any, do you have in the decision?*
- *Do you feel supported?*
- *How often does this happen on your unit?*
- *What concerns you most about this?*
- *How does it make you feel?*

Reflecting on your experiences of hallway healthcare, what are the impacts?
Depending on the participant's response, explore:
- *patient care, including family involvement*
- *nurses' work (e.g., nurse-patient relationships, patient care, safety)*
- *nurses' health and well-being (e.g., concerns, implications)*
- *broader issues related to hallway healthcare*